Effective Treatment for People in Homelessness Rehabilitation (Updated)

Part 1, Chapter 2

IN THIS CHAPTER

Introduction

In this chapter, you will meet several people with behavioral health disorders who are homeless or at risk of homelessness. Each person is introduced in a vignette that demonstrates effective approaches to treatment for people who are in different phases of homelessness rehabilitation (described in Part 1, Chapter 1) and who have a substance use and/or mental disorder. Prevention techniques and methods to reduce the incidence or manifestations of mental illness or substance abuse are also demonstrated.

Skills introduced in the seven vignettes include:

- Building rapport.
- Identifying client strengths, needs, preferences, and resources in housing and other life issues.
- Managing inappropriate behavior, requests, and expectations.
- Providing case management to access and coordinate housing and other services.
- Developing and monitoring treatment and housing goals.
- Assisting clients in improving coping skills.
- Adapting services for people who have cognitive problems.
- Adopting a trauma-informed approach to working with all clients who are homeless.
- Helping clients stay engaged in recovery despite ongoing mental illness/substance abuse symptoms.
- Recognizing the impact of co-occurring disorders (CODs) on recovery from homelessness.
- Helping clients find appropriate housing among the variety of options that may be available.
- Preparing clients to accept the terms of rental agreements and other housing constraints.

Each vignette begins by describing the setting, learning objectives, strategies and techniques, and counselor skills and attitudes specific

to that vignette. A description is given of a client's situation and current symptoms. Counselor–client dialog is provided to facilitate learning, along with a selection of aids that may include:

- **Master clinician notes:** comments from an experienced clinician about the strategies used, possible alternative techniques, and insights into what the client or prospective client may be thinking.
- **How-to notes:** step-by-step information on how to implement a specific intervention.
- **Decision trees:** aids to help you sort options and arrive at the best possible outcome.

The master clinician represents the combined experience of the contributors to this Treatment Improvement Protocol (TIP). Master clinician notes assist behavioral health counselors at all levels: beginners, those with some experience, and master clinicians.

Before using the described techniques, it is your responsibility to determine whether you have sufficient training in the skill set and to ensure that you are practicing within the legal and ethical bounds of your training, certifications, and licenses. It is always helpful to obtain clinical supervision in developing or enhancing clinical skills. For additional information on clinical supervision, see TIP 52, *Clinical Supervision and the Professional Development of the Substance Abuse Counselor* (Center for Substance Abuse Treatment [CSAT], 2009b).

For the convenience of the reader, the TIP refers in the vignettes to "counselor" generally rather than specifically by name. This will make it easier for the reader to track who is speaking at any given point in the vignette. As you are reading, try to imagine yourself through the course of the vignette in the role of the counselor. The seven vignettes are as follows:

- **Vignette 1:** Juan is in the outreach and engagement (O&E) phase of homelessness rehabilitation. This vignette demonstrates approaches and techniques for responding to his chronic homelessness.
- **Vignette 2:** Francis is in the outreach and engagement phase of homelessness rehabilitation. This vignette demonstrates approaches and techniques for responding to his health and safety concerns.
- **Vignette 3:** Roxanne is in the intensive care phase of homelessness rehabilitation. This vignette demonstrates approaches and techniques for preventing homelessness and stabilizing a client who is in the precontemplation stage of substance abuse treatment.
- **Vignette 4:** Troy is in the intensive care phase of homelessness rehabilitation. This vignette demonstrates approaches and techniques for preventing homelessness and engaging the client in substance abuse treatment.
- **Vignette 5:** René is in the transition planning/ongoing homelessness rehabilitation phase. This vignette demonstrates approaches and techniques for substance abuse relapse prevention.
- **Vignette 6:** Mikki is in the early intervention stage of homelessness prevention. This vignette demonstrates approaches and techniques for preventing additional trauma to her family because of temporary homelessness.
- **Vignette 7:** Sammy is in the permanent supportive stage of homelessness rehabilitation. This vignette demonstrates approaches and techniques for supporting access to housing for a client with serious mental illness (SMI) through programs partially funded by the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Projects for Assistance in Transition from Homelessness (PATH) program.

Vignette 1—Juan

Overview

Juan is in the outreach and engagement phase of homelessness rehabilitation. This vignette demonstrates approaches and techniques for responding to his chronic homelessness.

Juan is in his mid-thirties and is chronically homeless. He is dependent on crack cocaine, drinks alcohol, and occasionally smokes marijuana. He typically sits alone at a soup kitchen table. He knows who the outreach team members are and has walked away in the past when approached.

The outreach team has information about Juan from shelter staff members and other people who are homeless. He is unemployed but has worked in the past. Juan is hypersensitive to being "put down" by others. He is easy to anger, and his anger is often out of proportion to the stimulus. If he feels criticized, he will become sarcastic and will withdraw from interaction with others. He is very suspicious of the motives of others, often expecting that people have an agenda to disrespect him. These limitations have resulted in many losses: jobs, family relationships, apartments, and social supports. He has a history of being banned from shelters as a result of outbursts and fighting. The outreach team members believe that if they form a relationship with Juan and offer him a place to live, they will be able to engage him in treatment.

Substance use is believed to play a significant role in Juan's homelessness, so the member of the team who provides substance abuse counseling will take the lead in engaging him. The counselor's goals for the first visit are to:

- Meet Juan and begin to establish a relationship with him.
- Determine whether or not Juan will engage in a conversation about housing and other services.

Setting

The behavioral health counselor is a member of a community-based, interagency O&E team and works for a mental health and substance abuse treatment organization providing O&E services in collaboration with counselors, case managers, and outreach workers from other organizations. A Housing First program is available to clients through this interagency partnership.

Learning Objectives

- Use rapport-building outreach methods:
  - Accurately identify the client's beliefs and frame of reference.
  - Reflect the client's feelings and message.
  - Demonstrate empathy, respect, and genuineness.
  - Offer concrete assistance.
- Establish an initial plan based on the client's needs and preferences, community resources, and the intervention plan.
- Determine the client's stage of change; respond appropriately to changes in client behavior.

Strategies and Techniques

- Rapport and relationship building with a client who is difficult to reach

- Housing First as an approach to provide safe and stable housing
- Motivational interviewing (MI)

Counselor Skills and Attitudes

- Recognize and address ambivalence and resistance.
- Work as a member of a team to remove barriers to services.
- Emphasize client autonomy and development of skills.
- Show respect for both the client's needs and the organization's services.
- Help the client explore resources and determine which ones he would like to use.

Vignette

Visit 1 (soup kitchen)

The counselor walks to a seat near Juan at the soup kitchen, noticing that Juan watches her from the corner of his eye and appears tense. He sits alone and appears disinterested in the goings-on around him.

COUNSELOR: How's it going?

JUAN: Do you work here?

COUNSELOR: I work for the local outreach and engagement team.

JUAN: You're treating people?

[He talks to her, but his demeanor is aloof and suspicious, and he maintains his distance.]

> **Master Clinician Note:** Building relationships with people who are homeless proceeds at their pace. You can give people opportunities to accept assistance, but it is important that you consistently respect their choices. If someone refuses to talk to you, respectfully leave and plan to show up again with something the client might accept (e.g., coffee, socks, a chance to talk). Building relationships with soup kitchen workers who know the client can help you gather more information and facilitate a meeting.

COUNSELOR: No. I get to go out and spend time with people out here. Do you mind if I sit down? [*Juan nods.*] What do you think of the coffee here?

JUAN: Not too good. Better than nothin'.

COUNSELOR: Better than nothin', that's for sure. The food's okay?

JUAN: Yeah. This is a good place to eat, you know, a meal. What's *your* name?

COUNSELOR: It's Megan. How about yours?

JUAN: I'm Juan.

COUNSELOR: It's nice to meet you. So you've been in the area long?

[Juan says that he's been in town for a while and knows his way around. He's currently staying at a shelter that he doesn't like. The noise keeps him up at night, his things get stolen, and there are too many rules. He says he'd rather camp out, except for the police. The counselor mentions the possibility of housing.]

> **Master Clinician Note:** Nonclinical conversation is an important outreach tool. Social conversation is an icebreaker and helps identify a person's interests and needs. While the counselor talks with Juan, she listens for information that will help her guide him in creating a recovery plan—that is, information that may indicate some of Juan's strengths and limitations, problems related to substance use and homelessness, housing history, goals, values, and so forth.

COUNSELOR: If you were to have your own place, what would that be like for you?

JUAN: Well, that's what I do if I find a building where I can camp out. I make it my own place.

> **Master Clinician Note:** Having clients imagine themselves in a desired situation can help you identify what matters to them and the barriers to their goals. Open questions and reflection encourage Juan to elaborate.

COUNSELOR: You set up house.

JUAN: Right. Right now I don't have an income, so there's no way I can pay the rent or get a place, so I'm just making the best of what I got.

COUNSELOR: It's hard to imagine what it'd be like to move into your own place right now because it's hard to imagine how you'd get it. You don't have any income, and that's a problem.

JUAN: Right.

COUNSELOR: One of the things I do is help people find places to live that they can afford.

JUAN: Are you playing a game? You want me to go to treatment or something like that?

Housing First Models

Housing First approaches have been used to engage people who are chronically homeless and have severe and chronic mental illnesses. The goals of Housing First are to end homelessness and promote client choice, recovery, and community integration. Housing First engages people whom traditional supportive housing providers have been unable to engage by offering immediate access to permanent scatter-site independent apartments in buildings rented from private landlords. Clients have their own lease or sublease and only risk eviction from their apartments for nonpayment of rent, creating unacceptable disturbances to neighbors, or other violations of a standard lease. To prevent evictions, teams work closely with clients and landlords to address potential problems. Refusal to engage in treatment does not precipitate a loss of housing. Relapses to substance abuse or mental health crises are addressed by providing intensive treatment or facilitating admission to detoxification or the hospital to address the clinical crisis. Afterward, clients return to their apartments. Support services are often offered through multidisciplinary assertive community treatment (ACT) teams, with slight modifications.

Source: Stein & Santos, 1998.

COUNSELOR: No, you don't have to go to treatment to get into housing. We have a program called "Housing First" that might really be something you could look into.

JUAN: Well, I don't understand. Why would you do that for me?

COUNSELOR: I think somebody would do that for you if they thought you could do it successfully.

JUAN: My own place—somebody's gonna give me my own place?

COUNSELOR: Doesn't make a lot of sense to you, does it?

JUAN: No; what's the catch?

COUNSELOR: You and I would have to have a plan for how you would hang onto that place.

Master Clinician Note: The counselor demonstrates that the client can expect her to be honest about what to expect. As he considers making a change, it's natural for him to feel ambivalent about it and back off. This is part of the process of engagement, and the counselor doesn't want to prevent his ambivalence from arising. In the following exchange, she'll reflect both sides of his ambivalence so he can see the discrepancy between where he is now and where he wants to be. This is a technique from MI. Additional information on MI can be found in TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT, 1999b).

JUAN: Make a plan for how somebody wouldn't take it away from me.

COUNSELOR: How you'd be able to hang onto it, yeah. So that would mean income. Let me ask you this: When you got your last place, how did you do that?

JUAN: Uh, I got on assistance and they just took the rent out of that, so I never saw the rent check. But I got kicked out 'cause I had friends over, and we were partying. It got loud and somebody got into a fight, and then somebody else called the police. The next week I was out. I still get my disability assistance from the government.

COUNSELOR: So, a couple of things happened there. You got on assistance that paid the rent, you got your place, and then your friends came over and had a party. Things got loud and people started fighting, and that caused a problem.

Master Clinician Note: The counselor gathers housing history information and summarizes what Juan says to reinforce her understanding of how he lost his housing. Reflecting Juan's response empathically helps him feel heard and accepted and builds a mutual understanding of the issues they will need to address to make his plan for housing work. The counselor carefully avoids blaming Juan for losing his housing.

JUAN: Yeah. It's not like other people weren't having parties. They were having them every weekend, so I had a party, and the next week, I'm out of there.

COUNSELOR: It didn't make any sense to you that you were bounced out and other people got to stay, even though they were having the same kind of parties.

JUAN: Yeah. I don't want rules for when I can come and go or who I can have visit and stay over.

COUNSELOR: You want to be able to come and go as you please.

JUAN: Yeah. Just like anybody else paying rent for an apartment.

COUNSELOR: What other sorts of things do you think would be reasonable for a landlord to ask from you? Paying rent, that's one.

Master Clinician Note: Given Juan's history of homelessness and tendency to be irritable, the issue of reasonable expectations of a landlord is a touchy one. To avoid provoking Juan, the counselor is eliciting and reinforcing his understanding of reasonable expectations from a landlord.

JUAN: Pay for your rent. Take care of the place. Don't smash in the walls. Stuff like that.

COUNSELOR: Okay. So you wouldn't tear the place up and you'd pay the rent. The only other thing from the last story is that it sounds like maybe your guests might get a little loud.

JUAN: Yeah. I mean, what can you do in that situation? You ask the guys to keep quiet. If you try to throw them out, you may get hurt yourself.

COUNSELOR: You're not real sure what to do if they start being that way.

JUAN: Right.

COUNSELOR: So if we're going to make a plan, we might need to include some ideas about that for you.

JUAN: Like, no parties?

COUNSELOR: Well, how to deal with that kind of situation. We could look at your options and see what you'd like to do. How does that sound to you?

JUAN: You mean you're offering me a place now?

COUNSELOR: I'm offering to work with you to help you see if it's something you want.

Master Clinician Note: If the counselor agrees with Juan's understanding of her offer, then she's agreeing to help him find a home before they have agreed on how they'll work together to help him keep it. She's balancing good judgment with moving at his pace. From his history, she knows that if he's housed without being confident that he can adhere to the terms of a standard lease, he'll be at high risk for a return to homelessness.

JUAN: Yeah, I mean, I'd like that.

COUNSELOR: Well, there are a couple of things that you and I need to do. The first step is to begin to fill out an application where I'm going to ask you for—

JUAN: [*interrupts*] Filling out lots of papers?

[As they move toward beginning the process, Juan experiences more intense ambivalence. The counselor expected this and responds to it with acceptance.]

COUNSELOR: It's not pleasant, is it. How do you feel about that?

JUAN: [*irritably*] Eh, I don't need to get into that stuff. If that is where this is going, I don't want to go there. I don't need that stuff.

COUNSELOR: Okay. I can appreciate that.

[Juan's ambivalence intensifies. He backs his chair away and leaves, ignoring the counselor's request for him to wait. The next time she sees Juan, she tries to approach him, but he walks away.]

Visit 2 (shelter)

A few days after the first visit, the counselor finds out that Juan is at the shelter and stops by in hopes of bumping into him. Her goals for this meeting are:

- To reengage him.
- To offer him the opportunity to look at an apartment that has become available.
- If he wants the apartment, to see whether he can create a plan that will help him keep it.

Juan is cranky but agrees to talk to the counselor. He says he's been in the shelter for 4 days, that a staff member is badgering him into substance abuse treatment, and that he's getting ready to leave. Noting the opportunity, she reflects his wish for new accommodations and offers to take him to see an apartment.

COUNSELOR: So, you could use some options like maybe having a place to stay. We have an apartment that's become available, and the last time we talked, you sounded like you might be interested in something like that if it could be worked out to your satisfaction. I wonder if you'd be interested in taking a look.

JUAN: [*suspiciously*] Now?

COUNSELOR: Yes, I have a van here and a coworker from my outreach team. We can take you.

JUAN: All right, where is it? Not around here?

COUNSELOR: Well, it's not immediately around here. It's a few miles away.

JUAN: Well, I kinda like *this* part of town.

COUNSELOR: So that would be a big change for you, being way over there. Tough decision whether to go see a place that far out of your usual space. But, it's near a bus stop.

JUAN: Sure. Well, I'll go take a look at it.

[The counselor and her colleague drive Juan to the apartment. As she shows him the building, he mentions a landscaping job he had. He's proud of his landscaping abilities and describes being fired.]

JUAN: Yeah, I changed the garden around to make it better, and they told me I was doing stuff I wasn't supposed to do. They just didn't know what they were doing. I said, "I'm outta here."

COUNSELOR: I see. So as far as you're concerned, they didn't appreciate that you were taking initiative to try to make things better.

JUAN: Oh, yeah! Right on.

[They look around, and the counselor tells Juan he can move in when the paperwork is approved and they are able to reach an agreement to help him keep this apartment.]

COUNSELOR: We have to do the paperwork and work out a plan that makes you and everyone else feel confident that you would be able to keep this place.

JUAN: Like whether you're bringing in bags with bottles in them, or… ?

COUNSELOR: No, they don't complain about people bringing in bags with bottles in them. Remember that party you were talking about where things got heavy and the cops came? That's the sort of thing that would cause concern. You and I are going to have to figure out what the program guidelines are and what that means for you.

> **Master Clinician Note:** Juan is in the precontemplation stage of change for substance abuse and the contemplation stage of change for housing (see Part 1, Chapter 1, of this TIP). The counselor is seeking to enhance the relationship with him to support his engagement—first to obtain housing and then to help him move toward acting on other issues in his life, particularly his substance abuse.

[Juan agrees to go back to the shelter to start the paperwork despite his ambivalence. At the shelter, the counselor begins to collect information about Juan's housing history for the application. She mentions the party that led to his most recent eviction.]

COUNSELOR: We started talking about the parties and how those can disturb other people.

JUAN: Well, it's not like other people didn't have parties. I didn't complain about that.

COUNSELOR: So this is one of those areas where it may feel like you're being treated unfairly.

> **Master Clinician Note:** Again, the counselor is careful to reframe this issue to be about Juan's experience of what happened and avoid making him feel blamed, judged, or disrespected by the counselor. This is especially important given his sensitivity to feeling criticized.

JUAN: [*irritably*] I can tell you, I'm not gonna stop having my friends over.

COUNSELOR: Okay.

JUAN: [*still irritably*] What's the point of having your own place if you can't do what you want? I'm not saying they're gonna come over and bust the place up. I don't want that, either. But…

COUNSELOR: Well, you don't want people to come over and bust the place up and neither would any landlord. That makes sense to you. That seems reasonable.

JUAN: Yeah, sure, yeah. But these guys weren't fighting, nothing got broken, and they weren't any louder than the couple next door hollering at each other all the time.

COUNSELOR: Right. So, you feel like the thing that happened last time, the thing that caused the problem, you didn't feel it was as big a deal as they made it out to be.

JUAN: No. No way!

COUNSELOR: There really wasn't anything there for them to be concerned about at all.

Master Clinician Note: The counselor is using a technique known as "over-reflecting." This deliberate emphasis on Juan's initial opinion concerning the episode invites him to think more deeply about the episode and his feelings, evoking self-reflection, especially because he is a person who may not spontaneously self-reflect. There are risks with this approach—such as provoking defensive anger—but if presented with a nonconfrontational and supportive tone, even the most sensitive people will not respond negatively.

JUAN: No. They just didn't treat me right—with respect.

COUNSELOR: That was the problem; it felt like they were kind of singling you out.

JUAN: Yeah. And then that guy upstairs was always playing that #*%! speaker—I could feel the #*%!ing thing in my ceiling. Nobody else complained about that! They didn't kick him out.

COUNSELOR: Uh-huh. So part of what made you so angry the last time was that it seemed like everybody else was doing this stuff and not getting into trouble for it. You were the only one.

JUAN: Right!

COUNSELOR: It's hard for you to see what was different about your situation that got you kicked out.

JUAN: There wasn't anything different about this! They just need the excuse of their #*%!ing rules! I think it's better sometimes just to camp out. Nobody tells you what to do.

COUNSELOR: One of the things that's easier about camping out is that you don't have to deal with other people's ideas about the things you're doing.

JUAN: Right. If things get bad there, you just move off to another place, and that's cool.

COUNSELOR: That's right. You just keep moving around when it starts to get bad. So that's some of the good stuff about camping out; you don't have to put up with other people's complaints. If we're going to make this apartment work for you, we need to figure out how to help you manage those situations. I can't guarantee that the housing manager won't have some opinions about any parties you might throw.

Master Clinician Note: The counselor identifies a potential challenge for Juan in maintaining stable housing. The counselor avoids an adversarial stance by also commenting on the client's coping mechanisms in an accepting manner. Thus, the counselor attempts to begin to frame the issue of housing stability as an objective "problem" that would need to be "solved" by Juan with the counselor's support.

JUAN: Those guys, they weren't fighting, they were arguing with me. Maybe they got a little bit loud, but they didn't bust up the place.

COUNSELOR: That's another thing that might happen, right? You might have some friends over and they might just be hanging out, and somebody else might complain. That'd be tough for you to deal with.

JUAN: Yeah. What's the use of moving into a place and you have some friends over and somebody complains and they kick you out in a week? [*angry, dejected, and disgusted*] Hell, let's just give it up. I don't want to mess with this anymore.

COUNSELOR: Okay, I appreciate that.

[Juan abruptly leaves.]

> **Master Clinician Note:** The counselor knows that a lot is at stake for Juan; if he tries and fails, he might feel humiliated, so he's avoiding the risk of failure. This is a common response for people experiencing homelessness who are considering making a change. Some clients may experience ambivalence about change more intensely because failure causes them intense humiliation. Understanding this makes it easier for the counselor to accept Juan's ambivalence.

Visit 3 (soup kitchen)

Juan disappears for a few days. When he shows up at the soup kitchen, he looks like he hasn't slept for several days, seems to have been using, appears especially unkempt, and has a black eye and other bruises. The counselor asks if she can sit down. He shrugs with a disgusted look but says okay. She takes a seat.

The counselor says that Juan doesn't really look like himself today. Juan explains that he was attacked by someone outside the shelter. She asks whether he's had any medical attention. Juan says no and that he's not interested in getting any. He's not seriously injured, though his bruise looks ugly; the counselor's anxiety increases on seeing Juan's condition. She notices her anxiety and consciously relaxes so she can honor his freedom of choice instead of trying to push him to accept health care. She also notes that Juan gets into pretty serious fights despite portraying himself as someone who stays out of them. Juan agrees to have the counselor check in with him later.

The counselor discusses Juan's condition with her supervisor, and they decide that she should continue to check on him over the next couple of days and watch for any changes in his functioning. If she notices a decrease in his ability to function, she will address this again with him and with her supervisor.

Visit 4 (soup kitchen)

When the counselor finds Juan in the soup kitchen several days later, he looks better. His eye is healing, he's sleeping and eating better, and he has a decent spot on the street where he can get out of the weather. Her goal is to engage him into housing and other services.

COUNSELOR: So you're feeling like staying at this construction site is working for you?

JUAN: Just a little while. I mean, when they start opening up the fence and bringing in the big equipment and stuff, I won't be able to stay there. Are you still putting people in those apartments?

COUNSELOR: I certainly am. You think you might be interested in that?

JUAN: I don't know. There's all that rules stuff, people telling you what to do.

COUNSELOR: Well, it's a tough decision.

JUAN: On the other hand, I might only be able to stay at this construction site for another week.

COUNSELOR: You're getting to the point where you need a more permanent plan for where you stay.

JUAN: Yeah, it would be nice.

COUNSELOR: Yeah. You want to talk about it some more?

JUAN: Yeah.

COUNSELOR: One thing we ask is that you stay in the shelter a few nights before going into an apartment so we can get to know you a bit. We want to ensure that the housing fits your style and priorities.

> **Master Clinician Note:** The counselor avoids confrontation and allows Juan to save face while also emphasizing his need for success. *Note:* Housing First models generally don't require potential clients to spend any amount of time in a shelter prior to entering housing. Getting to know or assessing the client can occur on the street, in the Housing First program offices, or at sites in the community.

[Juan is concerned about returning to the shelter where he had the fight, because they made him leave. The counselor says some of the shelter staff members are familiar with Juan and his situation, and she'll talk to them about helping him possibly get his shelter housing back. Several days later, when they discuss Juan's situation with the shelter staff, Juan agrees to the shelter's rules and says he'd like to stay there until the apartment paperwork is complete and approved.]

Visit 5 (shelter)

Megan talks with shelter staff the next day and checks in with Juan. Her goals for the visit are to:

- Collect information for the housing application.
- Create a plan to address the issues that have caused Juan to lose housing in the past.

The counselor tells Juan that he has impressed the staff by staying out of arguments and not causing problems. She emphasizes this as Juan's accomplishment to reinforce his sense of pride in adaptive behavior. As we pick up the session, the counselor is collecting information about Juan's housing history.

COUNSELOR: So far, there are a couple of things I know. I know you've had an apartment before. And we've talked about what happened with that apartment. I'm wondering about other places you've lived.

JUAN: Actually, a couple different places. I had a friend, Tom. We shared a place for a while.

COUNSELOR: And how did you get that place?

JUAN: He got it. I don't know. He just asked me if I wanted to move in and split the rent.

COUNSELOR: Okay. And how were you affording your rent at that time?

JUAN: I was hustling, moving product—drugs and stuff. I didn't have a regular type job.

COUNSELOR: That's how you were getting the money to pay the rent and to use?

JUAN: Right.

COUNSELOR: So, that was one apartment you had with Tom. How long did that last?

JUAN: I guess about 2 months.

COUNSELOR: What other places?

JUAN: Well, when I was working for that landscaper, I had my own place for more than a year.

COUNSELOR: Oh, so that worked out well. That's a long time to hold on to a place.

JUAN: Yeah.

COUNSELOR: So you had the job first, and then got the apartment on your own.

JUAN: Yeah, those were some good times!

COUNSELOR: You liked that work, and you were good at it.

JUAN: Yeah. I liked being outside, working with the plants, seeing stuff grow and look nice.

[The counselor gathers the rest of Juan's housing, substance abuse, family, financial, and health history. The longest he's been housed is a year. He loses housing because of drug use and fighting. It's important to him to spend time with friends. The counselor notes that he will need positive social supports to maintain his housing. He reveals that he's on parole but hasn't seen his parole officer (PO) in 10 months. He's worried about an outstanding warrant. They discuss the need to address his legal issues, and the counselor offers her support through the process. Juan expresses some discomfort talking about his parole issues. Agreeing to set this aside for now, the counselor shifts the focus to Juan's relationship with his family.

Juan's brother lives upstate, and his parents live in town; he hasn't had contact with them for 3 years. He doesn't make contact with them because he believes that they're going to worry about him. The counselor believes his family could help support Juan's recovery. Once he's settled, he may be interested in inviting his family to his apartment, which could open a discussion about how his having an apartment is great but may also prompt conversation about his drug use. When the time comes to create a plan with Juan for substance abuse treatment, the counselor will ask about his interest in including his family in that plan.

The counselor assesses Juan's substance use and other likely problems based on what she already knows. They will use the information to create a plan to support housing stability and recovery. The counselor continues to gather information on Juan's substance abuse.]

COUNSELOR: We talked already about your use of crack. I wonder what other drugs you might use.

JUAN: I smoke a little grass every once in a while. Not on a regular basis.

COUNSELOR: So every so often, some pot. What else?

JUAN: I drink to come down. Wine helps me get to sleep.

COUNSELOR: Wine. What else?

JUAN: That's pretty much it, and all that other stuff I mentioned.

COUNSELOR: So you use some grass and some wine to come down. But the one you use most is crack.

JUAN: Yes.

> **Master Clinician Note:** Asking "what else?" and reflecting the client's response invites the client to elaborate. This lets the counselor explore client motivation for substance use without evoking resistance. Similarly, in the next exchange, she uses "tell me more" to gather details about psychiatric symptoms.

COUNSELOR: Okay. I'd like to ask you a couple of questions about just how you have been feeling. Have you been feeling depressed, sad, like you are not enjoying things that you might usually enjoy?

JUAN: I haven't been too good up here [*points to his head*] the past few weeks, so—

COUNSELOR: Well, tell me more about the past couple of weeks.

JUAN: I always wake up in the middle of the night and can't get back to sleep with guys playing music at the shelter and stuff, and that pisses me off.

> **Master Clinician Note:** The counselor is attempting to maintain and build the relationship with Juan through reflection, restating, and paraphrasing his comments. This is an effective technique from MI, although the counselor needs to be aware that the technique can be overused. If overused, rapport with the client will suffer.

COUNSELOR: So you are having some trouble sleeping. What else is going on?

JUAN: That's pretty much it.

COUNSELOR: That's pretty much it. What about feeling anxious or irritable and angry?

JUAN: Well, yeah. All those things.

COUNSELOR: All those things from time to time. Is there ever a point where they are really causing big problems for you or getting in the way of other things you want to do?

JUAN: Yeah. I walked off that job. That was a dumb thing to do.

COUNSELOR: So that's one case of feeling angry and making a choice you didn't really want to make.

JUAN: Yeah, that wasn't a good thing to do. It happens.

COUNSELOR: I hope that when you get settled in your apartment and when things are going better, we can talk about what happens when you get angry and get yourself in trouble.

JUAN: Yeah.

COUNSELOR: Juan, tell me some more about your sleep problem.

JUAN: Well, the wine just levels me off, helps me get to sleep. But then, when I drink a lot of wine, I wake up in the middle of the night and I can't go back to sleep.

COUNSELOR: Yeah, so that's sort of interfering with your sleep, too, you've noticed.

JUAN: I can't get to sleep without it, but then I wake up in the middle of the night.

[The counselor is supporting the client's growing awareness of the relationship between sleeping problems and substance use patterns.]

COUNSELOR: You drink wine to come down and fall asleep, but you've noticed that when you drink, you wake up in the middle of the night.

JUAN: Yeah, but it's better than going for a couple more days without getting any sleep.

COUNSELOR: How much sleep do you usually get?

JUAN: Don't know… 4 or 5 hours, maybe.

COUNSELOR: How much do you think you need?

JUAN: Maybe 6 or 7, 6 and a half hours.

How To Summarize for Your Client

Be concise. This makes for clarity and easier processing for the client. When summarizing:

- If possible, use the words and phrases the client has used.
- Be as accurate as possible in restating what the client seems to be trying to say. Try to not exaggerate or minimize what the client has said.
- Use phrases such as "What I am understanding is…" or "It seems that you're saying…" and check with the client to see if your understanding is correct.
- If the client says you are not understanding, ask him or her to tell you again and use the client's words in your feedback.
- Sometimes, it may be important to let the client know that understanding what he or she is saying does not imply approval of potential actions. For instance, if a client says they want to hurt someone else, be sure your feedback does not imply that you agree with their intent.

COUNSELOR: How often do you usually get that?

JUAN: Huh! Almost never.

COUNSELOR: Not very often. So you walk around sleep deprived most of the time.

JUAN: Well, I never really thought about it that way. I'd like to sleep longer.

COUNSELOR: Yeah. You and I could work on ways to get a good night's sleep, and you've already connected wine with trouble staying asleep, and you have trouble falling asleep.

JUAN: Yeah. Without the wine, I lie in bed a long time before I drop off.

COUNSELOR: We could see what we can do to help you, if you would like us to do that.

JUAN: I don't know what, but yeah, if something can be done, I'm all for it. Maybe later.

Master Clinician Note: The counselor suspects, from the symptoms Juan has described, such as depression, anger, and anxiety reactions, that he might have a trauma disorder, but she avoids probing his trauma experience, which might, given his situation now, destabilize him and/or disrupt their developing rapport. Instead, she focuses on Juan's main related concern: sleep. She helps him see how these symptoms may be related to substance use. Once Juan has stabilized in housing and is possibly more receptive to engaging in counseling, she will help him access care for both his substance use disorder and, if necessary, his trauma disorder. For more information on working with clients who have trauma symptoms, see the planned TIP, *Trauma-Informed Care in Behavioral Health Services* (SAMHSA, planned h).

COUNSELOR: Okay. Do you ever have any beliefs that other people don't have, or do you see things other people don't see or hear things other people don't hear?

JUAN: No. I'm not crazy, man.

COUNSELOR: That's not you. Are there other problems you want me to be aware of at this point? Anything else that you would like us to work on?

JUAN: Just the apartment.

COUNSELOR: The apartment. So at this point, we've completed this paperwork. The housing program will discuss this application, and we will get an arrangement that we can all agree to.

JUAN: Okay.

COUNSELOR: So, some of the things we've talked about working on are sleep, legal issues, anger, and how to manage things when situations aren't fair. Is that about right?

JUAN: So when can I move in?

Master Clinician Note: Juan doesn't respond with "yes," which shows that he's not yet committed to working on these issues. The counselor must reexplore the issues with Juan to identify which ones he's ambivalent about.

How To Prepare a Client for a Conversation With a Parole Officer

When your client agrees to contact his or her PO to explore options, help prepare as follows:

- If your client isn't ready for treatment yet, it's reasonable to expect him or her to leave if the PO says going back either to jail or to treatment is necessary. Discuss the consequences of leaving (e.g., the possibility of being remanded to jail) and tell your client that, no matter the outcome, he or she is welcome to come back for help in the future.
- If your client is ready for substance abuse treatment, you can indicate that sometimes, when people agree to accept treatment and stay in it for a while, POs agree to remove the warrant.
- If parole concerns are a significant burden to your client, help him or her envision what it will be like to be rid of them. The PO might require substance abuse treatment or enforce jail time, but after, it will no longer be a concern. If needed, the two of you can work together on a plan for making it through treatment or jail time.

COUNSELOR: Well, we went over a lot just now. We want to make the housing plan really work for you. Next, we'll review your application and get our agreement in place. You can have a little more time to think about what I just summarized as part of your plan. Tomorrow, let's review the whole thing and make a housing plan we feel really good about—one that will give you the best shot at making it stick with the landlord. Now, let's talk about contacting your parole officer and get that sorted out.

JUAN: Yeah, well, I'm outta here if the PO's got a warrant on me.

[The counselor and Juan proceed to discuss what is going on between Juan and the PO. Juan and the counselor briefly role-play Juan talking to the PO.]

COUNSELOR: Do you want to call him now, while I'm here?

JUAN: That sounds okay. If he doesn't go along with this, then everything else is out.

COUNSELOR: Right. We should talk with the PO first. We can use the speaker phone to hear both sides of the conversation. We'll see how that goes, then decide about talking to the team about your plan.

JUAN: Yeah, let's do that.

COUNSELOR: Juan, I'll need you to sign this "release of information" form that authorizes me to talk with your PO and provide him with information about our work so far. Is that okay?

JUAN: Okay, where do I sign?

[The counselor helped Juan prepare for his meeting with the PO by using some of the guidelines noted in the how-to box above. Juan's PO determined that he could avoid incarceration if he stayed in the shelter for homeless services. Juan did move into the Housing First program, and he and the counselor continue to work on his multiple problems. Likewise, the counselor continues to work on engagement, helping Juan move from precontemplation to the contemplation stage with his substance abuse. The counselor, using MI methods, has helped Juan examine how his ambivalence and sensitivity often prevent him from initiating actions that could be helpful to him.]

Summary

Juan's story took place in the O&E phase. The work focused on:

- Establishing a trusting relationship through nonintrusive persistence.
- Identifying acceptable goals to work on.
- Maintaining teamwork among the counselor, Juan, and the interagency O&E team.

Teamwork was central to Juan's willingness to talk to the counselor, see the apartment, regain access to the shelter (and thereby move toward housing), begin the application process, and explore his legal status.

The counselor helped Juan move through the stages of change by prioritizing Juan's most important goals. Juan began in precontemplation for substance use and mental disorders and the contemplation stage for housing. Housing became the highest priority goal; this let the counselor and Juan identify barriers to maintaining stable housing and reasons to engage in other services. Juan is now in the action stage for obtaining housing and the contemplation stage for substance abuse, mental illness, and legal issues.

Juan's personality problems, such as his hypersensitivity to criticism, his feelings that people are against him, and his sudden anger, may be his most challenging issues. They will be identified as concerns in his treatment after he becomes abstinent, manages trauma disorder symptoms, and develops a resilient, trusting relationship with his treatment team. At this phase of homelessness rehabilitation, the clinician can address behavioral issues by:

- Demonstrating respect for and acceptance of his feelings (e.g., anger, sense of unfairness).
- Helping him see how his behavior (e.g., hosting loud parties, leaving his job) contributes to his homelessness.
- Setting a goal of working on alternative responses to problem situations.

Longer-term goals for this client will include:

- Creating a plan that Juan is confident he can accept and comply with for housing.
- Reconnecting him with family and other natural recovery supports.
- Working with treatment providers to engage him in substance abuse treatment.
- Reconnecting him with employment and other meaningful roles in the community.
- Addressing his parole obligations.
- Evaluating him for mental disorders.

Vignette 2—Francis

Overview

Francis is in the outreach and engagement phase of homelessness rehabilitation. This vignette demonstrates approaches and techniques for responding to his health and safety concerns.

Francis is a 54-year-old man who is chronically homeless and has limited interpersonal and intellectual resources. He is now a loner and has had difficulty in the past maintaining a place to live. He currently lives in a subway tunnel, is suspicious of anyone who approaches him, and worries that the transit authority will put him out. He can be personable, and he often spends his day at the entrance to the subway. The outreach team has learned that Francis has occasionally gone to

the local community health center, which is a Federally Qualified Health Center (FQHC; see the text box on p. 81), during the past 4 years. According to his clinic records, he has mild intellectual disabilities (intelligence quotient [IQ] near 70) and may have cognitive impairments as a result of a head injury incurred many years ago. He receives a small disability check monthly. The money is managed by a designated payee, a person who is authorized to help Francis manage his money. He also receives Medicaid as a result of his disability.

The program has been in contact with Francis for some time. He has always walked away after insisting that he is fine and doesn't need anything. The O&E team has new information from area shelters that he's building cooking fires in inappropriate places. In addition to his cognitive impairment, he has significant health problems, including diabetes and nutritional deficiencies. This information, along with an impending severe cold spell, mobilizes the O&E team to persist in trying to engage Francis in services.

A team of two counselors plans to meet him, briefly assess his situation, offer material goods, and establish a relationship. Getting him to accept shelter, health care, and ongoing support are long-term goals. The present goals are to engage him in any possible way to improve his safety and to find opportunities to offer other services.

Maintaining the safety of O&E team members is a critical element of this type of work. Francis's location has been reviewed and approved as safe by the team. (Sample safety policies and procedures are located in Part 2, Chapter 2.)

Setting

The counselor team is part of a multiservice organization serving homeless populations; its street outreach component is staffed by peer counselors, substance abuse specialists, psychiatric social workers, and consultant psychiatrists. It has a drop-in center, housing resources, a working agreement with a local FQHC, and ties to community homelessness programs.

(Note: The designation of FQHC is based on specific funding and reimbursement criteria. There are a number of community health centers that may have an FQHC designation; however, there are other community health clinics and health centers that may not.)

Learning Objectives

- Build rapport (offer material goods; engage in casual conversation; work at the client's pace; show empathy, respect, and genuineness).
- Assess the severity of the client's problems (e.g., safety, health) and develop responses.
- Work with others as part of a team.

Strategies and Techniques

- Outreach
- Match client and counselor
- Service coordination with a local health clinic, a Federally Qualified Health Center

Counselor Skills and Attitudes

- Build rapport.

- Work collaboratively with the client and others.
- Recognize and accept the client as an active participant in prioritizing needs.

Vignette

Visit 1 (Francis's camp)

During this visit, the team will:

- Initiate a relationship, begin to build trust, and establish rapport.
- Offer Francis food and a blanket.
- Tell Francis the weather is turning cold and offer to take him to a shelter.
- Assess Francis's condition.

The two counselors slowly but casually approach Francis, who is seen lying down and snoozing among some of his belongings. He's bearded, disheveled, dressed in dirty clothing, mildly malodorous, and grimy. He is a large man, but he seems physically weak and malnourished. He awakens spontaneously as they approach but is unfocused and seems confused. Team members introduce themselves and shake Francis's hand. He doesn't know who they are and, fearing police or transit officials, he gets up, covers some items, picks up others, and begins moving away.

COUNSELOR 1: Hey.

FRANCIS: Hi.

COUNSELOR 1: How are you doing?

FRANCIS: I'm good.

COUNSELOR 1: Good. My name is Alex, by the way. [*gestures to colleague*] This is Tommy. [*Francis acknowledges them minimally.*] We were just coming by here and noticed that you looked kind of down in the dumps a little bit. How are you doing?

FRANCIS: I'm fine.

COUNSELOR 1: Good. Did we startle you?

FRANCIS: Are you the police?

COUNSELOR 1: Oh no. We work down here in the tunnels and meet people who may be living down here or staying down here. Have you been down here for a while?

How To Engage People Who Are Living on the Street

Several tools can help outreach workers engage a person who is living on the street:

- Observe from a distance to get a sense of what the person may need and how he or she is doing.
- Approach respectfully. Ask to join the person at his/her bench, campsite, or other personal area.
- Offer safety-related items that he or she appears to need (e.g., food, shelter, blankets, water).
- Resist the temptation to offer items solely for comfort rather than safety, as this may support the client in refusing services. The goal is to develop an empathic relationship that respects the client's wishes and creates opportunities to help the person become housed and enter treatment.
- Unless the individual indicates a willingness to have a longer conversation, keep your interactions brief (about 2 minutes) to avoid wearing out your welcome.

FRANCIS: Yeah.

COUNSELOR 1: What's your name, sir?

FRANCIS: Francis.

COUNSELOR 1: Hi, Francis.

FRANCIS: Hi.

COUNSELOR 1: It's getting kind of cold. Can I help you somehow?

FRANCIS: No.

COUNSELOR 1: Okay. Can we sit down?

FRANCIS: Yeah.

[After receiving permission to do so (it is Francis's "home"), the outreach workers sit down. This encourages Francis to stay and talk with them. He makes eye contact and starts to pay attention.]

COUNSELOR 1: So how long you been staying down here?

FRANCIS: Not long.

COUNSELOR 1: Um, I was thinking that it's getting kind of cold out. You said that you were okay. I just wanted to check and see if we could offer you a place to stay indoors.

FRANCIS: No, I'm fine. I went to the health clinic.

COUNSELOR 1: You did? Is that the one over on Second Avenue?

FRANCIS: Yeah.

COUNSELOR 1: I notice that your ankles look pretty swollen and red. Does that hurt?

FRANCIS: A little, but not all the time.

COUNSELOR 1: Is that what you went to the health clinic for?

How To Work as a Team Member on an Outreach and Engagement Team

Agencies often have policies supporting teamwork during outreach. Successful O&E teams collaborate on plans for outreach visits and respect each other's opinions. In Francis's case, the team agreed on the following:

1. O&E will proceed at the client's pace unless there is reason to fear that this will endanger the client (see the decision tree on p. 77).
2. Specific problems will be addressed as the client is willing. Team members work together to create opportunities to offer assistance in resolving these problems.
3. Team members should define roles in advance, especially in terms of who will take primary responsibility for the interaction.
4. Team members should observe which worker the client prefers to speak with and respect that choice. Workers not speaking directly with the client will help in other ways by remaining alert to the needs of both the client and their colleagues.

[Counselor 2 suddenly notes that Francis is becoming uncomfortable, looking away and beginning to pick at his clothes. The counselor assumes that his partner is being too directive with questions and, glancing at his partner, decides to take another approach.]

COUNSELOR 2: How are you doing in the food department? Can I offer you a sandwich?

FRANCIS: Yeah.

COUNSELOR 2: [*handing him a sandwich*] Here you go.

FRANCIS: Thanks.

COUNSELOR 2: Sure. One of the reasons we are down here is that we're moving into a real cold spell over the next couple of days and, you know, when it gets cold, how do you usually manage yourself?

FRANCIS: [*making eye contact*] I'm fine. I have a bag.

COUNSELOR 1: A sleeping bag, you mean?

FRANCIS: Yeah.

[Francis shows the counselor a warm sleeping bag in good condition.]

COUNSELOR 2: Do you need anything else from us? Like a blanket, maybe?

FRANCIS: Um… sure.

COUNSELOR 2: [*handing him a blanket*] Here you go.

FRANCIS: I'm through talking with you now.

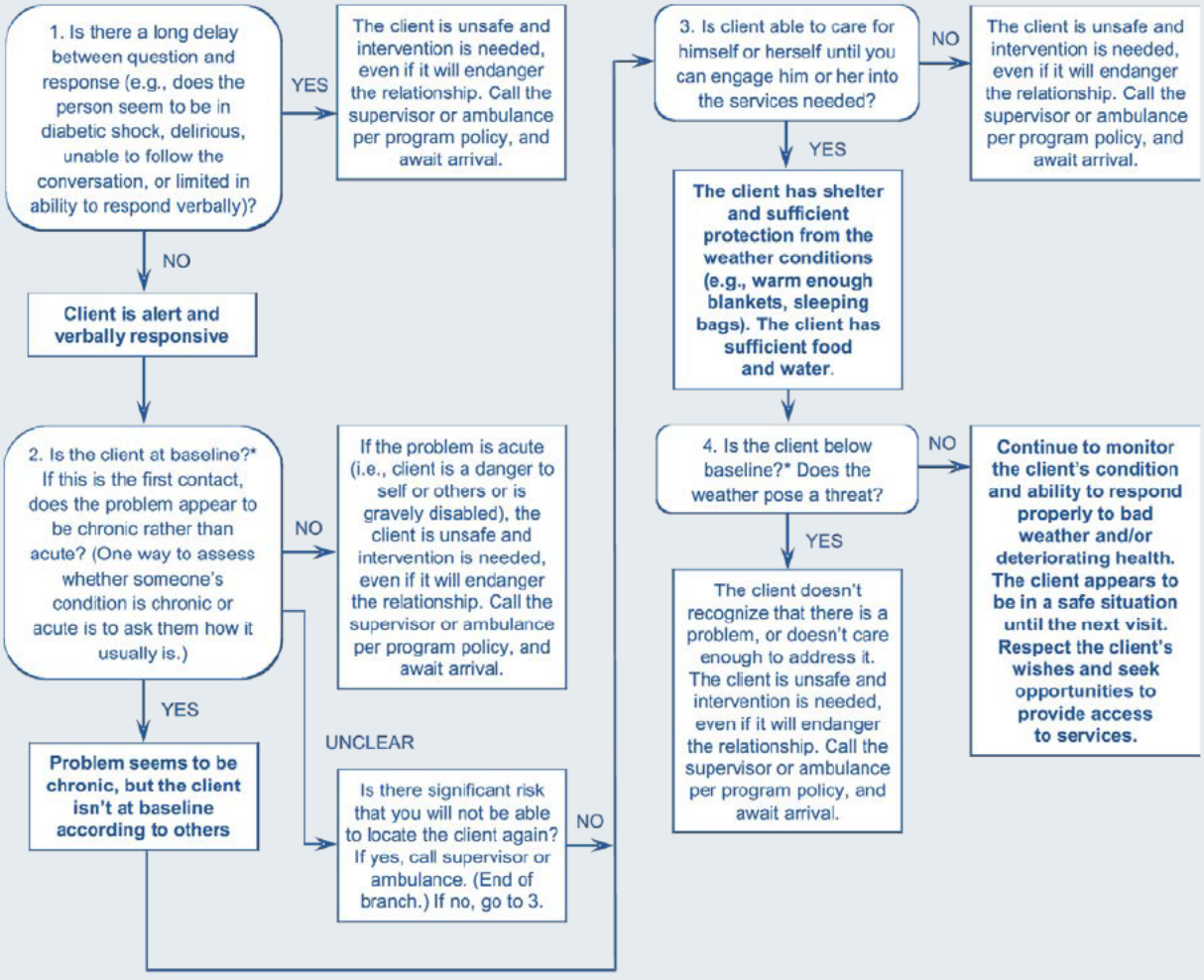
COUNSELOR 1: Okay, I'll tell you what—we'll come back and see you another time. Can we do that?

[Francis agrees, and the outreach team says goodbye and walks away. After the visit, the two counselors report to the rest of the O&E team (consisting of a psychiatrist, a social worker, peer counselors, and a substance abuse treatment provider) and discuss the temperature and whether to do something to ensure Francis's safety. They decide that his situation isn't that bad; he responded appropriately to all questions, is sheltered from the weather, and has a good sleeping bag. They're concerned that he'll move now that he's been approached but decide that his camp looked well set up. That, coupled with his making eye contact and accepting food and a blanket, suggests that Francis will be in his camp the next day. They're concerned about his health and make a plan for the counselors to visit him frequently to monitor his general condition and the condition of his ankles, along with his ability to take care of himself in the cold. If the opportunity arises, they'll try to look at his feet. They plan to engage him in medical and other services at his pace and to take him some socks.

The decision tree on the following page indicates how providers might decide whether and how to intervene when a person who is homeless declines services.]

Decision Tree: Appropriate Follow-Up Care When Concerned About a Person Who Refuses Services

When you detect a client problem in terms of health, cognition, possessions, inclement weather, or change in baseline, you must decide how to respond. In Francis's case, the team decides to monitor him closely and seek opportunities to get him to medical services or bring the services to him. How did they make that decision? This decision tree maps out their process—the team's decisions are in bold.



*"Baseline" refers to a condition perceived to be stable.

Visit 2 (Francis's camp)

The next day, the O&E team members visit Francis again. Their goals are to:

- Offer him their business cards so he has a way to contact them.
- Offer him information about a new, smaller shelter that has opened up nearby.
- Make sure he knows that the weather is going to get even colder tonight.
- Observe his overall condition, the status of his feet, and his ability to take care of himself.
- Give him some socks.

COUNSELOR 1: Francis? It's Alex and Tommy. Remember us from yesterday?

FRANCIS: Yeah.

COUNSELOR 1: Good. Man, it was cold last night! How did you do?

FRANCIS: I did fine.

COUNSELOR 1: I see you're fixing up a little bit more space for yourself here.

FRANCIS: Yeah.

[Francis attempts to stand and stumbles. He appears to be physically uncomfortable.]

COUNSELOR 1: Can we give you a hand?

FRANCIS: No, I'm fine.

COUNSELOR 1: Okay. Hey listen, you know—that shelter up on Avenue A has opened up and there's a spot in case you need it, because it's getting really, really cold. Is that something we can help you with?

FRANCIS: No. I'm fine.

COUNSELOR 1: Okay. Well, we brought some socks for you; would you like some socks?

> **Master Clinician Note:** Giving Francis socks is a nonverbal intervention that shows concern for his health and safety. It shows Francis that the team is connecting with his needs and is interested in building an alliance.

FRANCIS: Yeah. Thanks.

[Tommy hands Francis the socks.]

COUNSELOR 1: We'd also like to give you our cards in case you need to go to the shelter. We'll be around. Is it okay if we come back and see you again?

FRANCIS: Thanks. Yeah, you can come back.

COUNSELOR 1: Okay. Good. Give us a call if you need to. There's an 800 number there. Feel free to just call that number if you need us. We'll come back and see how you're doing in a while, okay?

FRANCIS: Okay.

COUNSELOR 1: There is a telephone right up at the top of the subway entrance, and this is an 800 number, so you don't need to use coins. You just dial this number. Is that okay with you?

FRANCIS: Okay.

Visit 3 (Francis's camp)

On their third visit to Francis's camp several days later, the O&E team has the following goals in mind:

- Continue to develop a relationship with Francis.
- Introduce Francis to the idea of getting follow-up medical care.

- Look for ways to connect him to housing opportunities.

COUNSELOR 1: Hey, Francis.

FRANCIS: Hey, how you doin'?

COUNSELOR 2: Hey, how you doing, Francis?

FRANCIS: Good.

COUNSELOR 1: I heard that you were in the shelter the other day.

FRANCIS: Yeah. I was there for a couple of days.

[Francis struggles to stand up—even though he is obviously in some pain—and he stumbles. The counselor reaches out his hand to help Francis stand and steady himself.]

COUNSELOR 1: Let me give you a hand there.

FRANCIS: Ow! I went to the clinic 'cause my foot was hurting a little bit, and they said I should go to the shelter.

Master Clinician Note: Francis has shown that if he really needs medical care and shelter, he can get them. This indicates that, despite some cognitive impairment, he uses good judgment in at least some situations. Cognitive impairment has a broad range of severity, from mild forgetfulness to full disorientation as to time, place, and person. Cognitive impairment may also be temporary or chronic. Because thinking can become disordered or inefficient, cognitive difficulties can impair judgment by compromising a person's ability to evaluate the risks and benefits of any choice. The causes of cognitive impairment are many, but it may result from a head injury, malnutrition, alcoholism, or acute physical illness. The presence of clear cognitive impairment signals the need for a prompt medical evaluation.

COUNSELOR 1: Yeah, it looks pretty raw right down there. Looks really painful.

FRANCIS: No, it really don't hurt that much.

COUNSELOR 1: Really? I see that your shoes are in kinda bad shape too. So you've been walking around in shoes with holes in them, and it snowed the night before last, too, didn't it?

FRANCIS: Yeah.

COUNSELOR 1: The weather must've been pretty bad on your foot. That's why you went to the clinic?

FRANCIS: Yeah.

COUNSELOR 1: Well, you know, Tommy and I were talking, and we were thinking you could probably use a better place to sleep at a certain point; you know, indoors, in an apartment. Is that something you might be interested in at some point in time?

FRANCIS: Nah. I'm pretty fine out here. I mean, it's not too bad.

COUNSELOR 1: But when it gets cold, it gets a bit rough, and right now it's kinda tough.

FRANCIS: I'm pretty much a tough guy.

COUNSELOR 1: Yeah. I know. How long have you been staying outside? When was the last time you had your own place?

FRANCIS: Oh, about 3 years ago. Yeah, me and my buddy got a place. I moved in. It was pretty nice and everything. He kinda got sick a little bit. My friend passed away.

COUNSELOR 1: Oh, he did? I'm sorry.

FRANCIS: Yeah, it kinda was his place, so I couldn't stay there any longer.

COUNSELOR 1: Got it. You had trouble making ends meet and stuff like that after he passed.

FRANCIS: Well, yeah. It was hard.

COUNSELOR 1: Well, Francis, we'd like to help you find some better housing if you are interested.

FRANCIS: I'm fine.

COUNSELOR 1: Okay. Well, it's something to think about, and we would be glad to talk more about it.

FRANCIS: Okay.

COUNSELOR 1: I'm a little concerned about your foot, though, especially the pain you're going through.

FRANCIS: It's not much pain. I've seen worse. [*rubs his shoulder*] I was shot a long time ago.

COUNSELOR 1: Oh really? Can you use that shoulder pretty good?

FRANCIS: It's fine. Sometimes it hurts a little bit.

COUNSELOR 1: Just so you know, at the clinic there's a nurse in charge of foot problems, and if you'd like, we could take you down there to have her take a look at it if you want.

FRANCIS: You mean Miss Kate. I know her. She's nice. But I don't know. Like I said, it don't hurt that much.

COUNSELOR 1: Okay. It's a little raw. I'm concerned about you with your shoes in bad shape and stuff. You know, at the clinic, they might be able to set you up with a new pair of shoes.

FRANCIS: Can *you* get me some shoes?

Master Clinician Note: This is the first request Francis has made of the O&E team, and they take this window of opportunity to let him know that they want to help him get what he needs. Offering concrete aid like this fosters engagement because it shows Francis that the team will respond to his manifest needs. Counselors will want to be sensitive to clients making a request as a test of whether the counselor and other members of the staff will really respond to the client's expressed needs.

What Is a Federally Qualified Health Center?

A Federally Qualified Health Center is one that is qualified to receive Federal Medicare and Medicaid funds for delivering services to persons enrolled in those programs. In addition, an FQHC program may be eligible for grants to provide services to special target populations, such as individuals and families experiencing homelessness. Typically, FQHCs are found in areas that have large populations of medically underserved individuals and/or in areas with high concentrations of migrant and seasonal agricultural workers, significant numbers of people in public housing, or high rates of homelessness. FQHCs are located in every State.

FQHCs are directed by a community-based board of directors and provide comprehensive primary health care regardless of a person's ability to pay. Fees are based on the individual's ability to pay. Additionally, many preventive services are offered, including screening, brief intervention, and referral to treatment (SBIRT) for individuals at risk of substance abuse and substance use disorders. For more information, see https://www.cms.gov/MLNProducts/downloads/fqhcfactsheet.pdf.

COUNSELOR 1: Yeah, we can bring you some shoes the next time we come. Would it be all right with you if I bring a worker from the clinic? They can help you get medical care for your feet.

FRANCIS: Yeah.

COUNSELOR 1: Okay, great. Take it easy, all right? By the way, what size shoes do you wear?

FRANCIS: I don't know. Size 10, I think. Okay, see you later.

[The team will ask the FQHC clinic's homeless program case manager to join them on their next visit with Francis. They intend for the clinic staff person to become Francis's case manager and help him access medical care, possibly obtain permanent supportive housing, and access other services. During the visit, the clinic case manager will take engagement and intervention cues from the O&E team.

The team feels hopeful that they will get medical attention for Francis's feet on their next visit. Francis has demonstrated that he'll go to the clinic when the pain becomes limiting, but the immediate risk to Francis is that his feet are probably numb as a consequence of his diabetes. This creates a risk of injury and infection, which can lead to serious complications.]

Visit 4 (Francis's camp)

The team approaches this visit with the following goals and strategies in mind:

- The clinic case manager will accompany them and begin to establish a relationship with Francis.
- The team will offer Francis food, shoes, and a ride to the clinic, where he can have his foot examined.
- If Francis fears being coerced into unwanted services, they'll promise to return him to his camp.

Francis is at his camp and is irritable. He didn't go to the shelter and is cold and obviously unhappy. The two counselors introduce the clinic case manager to him.

COUNSELOR 1: Hey, Francis.

FRANCIS: Hey.

COUNSELOR 1: You know, I said we'd be back in a day or two, but we've been thinking about your situation with your foot. We called up the clinic, and they were concerned. Let me introduce Jesse to you.

CLINIC OUTREACH WORKER: Hi, Francis. Yeah, I've seen you come by the clinic a couple of times. I think we spoke once. My office is just as you enter the clinic out of the waiting room, on the right. You know, we can help you with that foot, man.

COUNSELOR 1: Yeah. We can take you to the clinic and then bring you back here if you want.

CLINIC OUTREACH WORKER: Yeah, we can do that. You don't need to stay here.

FRANCIS: I don't need no help.

COUNSELOR 1: A nurse can look at that foot.

FRANCIS: Didn't I just tell you I don't need no help?

> **Master Clinician Note:** The counselor appraises the situation and realizes that the introduction of another person with whom Francis has not had a chance to develop rapport and, possibly, the pressure Francis perceives about getting help are causing Francis to resist. Rather than provoke the resistance, the counselor takes the opportunity to change the topic and talk about the weather for a few minutes. He then returns to the discussion of Francis going to the clinic for health care.

COUNSELOR 1: Well, man, I hope you are going to be willing to let Jesse help you get over to the clinic and get that foot taken care of.

FRANCIS: That's all we're gonna do, right?

CLINIC OUTREACH WORKER: Yeah. It's your call. Can we take your stuff with us?

FRANCIS: Yeah. If you don't take things around here, they…

CLINIC OUTREACH WORKER: Yeah, I know. They get taken by somebody else.

FRANCIS: So are we going to the clinic that I go to?

COUNSELOR 1: Yeah, that's where the nurse is. She'll look at your foot and we'll get some food for you—a sandwich and some hot coffee. How do you like your coffee?

FRANCIS: All black.

[Once the team has promised not to leave him at the clinic, Francis agrees to go with the outreach worker. He's now in the preparation stage for medical care and the precontemplation stage for assistance with housing.]

Summary

This vignette demonstrates counselor skills and attitudes involved in outreach work, including:

- Patience, respect for client autonomy, and trustworthiness.

- Relationship-building skills.
- Ability to respond appropriately to changes in the client's behavior.
- Ability to work as a member of a team and respond appropriately to safety and medical needs.

In the O&E phase, the team's interventions suited Francis's stages of change: contemplation and preparation for medical treatment, and precontemplation for housing. They prioritized the goal most pressing to Francis and his well-being: addressing his medical problems. Interventions to build a relationship and increase readiness for services included:

- Asking for permission and respecting his decisions and personal space.
- Offering incentives (e.g., socks, blanket, shoes, food).
- Increasing access to services (e.g., bringing workers to him, helping with transportation, helping him take his things with him).

Given Francis's willingness to engage *on his terms*, agreement to engage in additional services will also be on his terms. As shown in this vignette, Francis moves forward assisted by the creativity, care, respect, and persistence of the counselors who work with him. The challenge for the counselors is to continuously balance Francis's freedom of choice with the severity of his condition.

Long-term goals for working with Francis include:

- Help him engage in medical treatment at the clinic to stabilize his current medical conditions.
- Evaluate his mental health, particularly in light of his cognitive impairments.
- Make a plan that he's confident he can adhere to for housing.
- Reconnect him with his family and other recovery supports.
- Connect him with other peer-led community recovery supports.

Vignette 3—Roxanne

Overview

Roxanne is in the intensive care phase of homelessness rehabilitation. This vignette demonstrates approaches and techniques for preventing homelessness and stabilizing a client who is in the precontemplation stage of substance abuse treatment.

Roxanne is 32 years old, has been diagnosed with antisocial personality disorder, and is possibly dependent on oxycodone and other opioids. She occasionally has sex in exchange for money and sells pain pills for income. Roxanne lives in a supportive housing program, but her behavior has put her housing at risk. Her hostility, impaired ability to regulate her emotions, physical complaints, self-destructive and impulsive behavior, and impaired relationships may be indicative of a trauma-related disorder as well as a personality disorder.

These behaviors may evoke an emotional reaction (countertransference) in the counselor, evidenced in this case by the counselor's anger, frustration, and helplessness. This makes it hard for the counselor to respond effectively to Roxanne's needs. Supervision in such a situation is quite important and can help the counselor clarify boundaries, responsibilities, and strategies for holding Roxanne responsible for her behavior while providing support to facilitate behavior change.

Roxanne's behavioral health counselor has talked to her many times about using drugs, bringing men paying for sex to her single room occupancy (SRO), and "shopping for pills." Even so, Roxanne continues to have her clients "visit" her in her room. She also continues to seek drugs for severe chronic back pain—particularly oxycodone—in local emergency departments (EDs). She has been evaluated on several occasions for pain (including comprehensive studies of her back and spine in the hospital pain clinic), but no evidence of a physical disorder has been found. About 2 years ago, she was referred to the hospital pain management program but did not follow through with their recommendations. She has had two admissions to a local mental health treatment center, both times following arrests for disorderly conduct and resisting arrest.

The clinic suggested that she might have posttraumatic stress disorder (PTSD) and/or a substance use disorder in addition to her personality disorder, but these diagnoses were not confirmed, and Roxanne refused to continue to be seen at the clinic. She did agree to enroll in a hospital case management program for ED users that includes consent to share information with the behavioral health counselor in her SRO. The ED has called the counselor to report that Roxanne is now there and is refusing to leave without medication, even though she has been examined and released with a clean bill of health.

Setting

The behavioral health counselor provides case management services for a community program offering a variety of housing options to clients with a history of substance use disorders or SMI. All of the clients have had mental health and/or substance abuse treatment. The level of recovery varies from very stable to active symptoms that interfere with daily functioning. In most cases, a client's level of recovery determines the housing options available to him or her. In this case, the counselor provides services to clients housed in an SRO supportive housing program funded through the U.S. Department of Housing and Urban Development (HUD). The housing consists of units with a kitchen and bath for occupancy by one person.

Learning Objectives

- Tailor treatment strategies, including the use of incentives, to match the client's motivational level.
- Work with others as part of a team.
- Recognize situations in which supervision is appropriate.
- Work with clients experiencing homelessness who are in the precontemplation stage of change for their substance abuse.

Strategies and Techniques

- Behavioral interventions, including contingency management
- Structuring sessions
- Managing and setting limits on inappropriate behavior

Counselor Skills and Attitudes

- Work collaboratively with the client and others.
- Recognize and accept behavioral change as a multistep process.
- Take responsibility for personal and professional growth (e.g., address countertransference).

- Adjust strategies to suit client characteristics (e.g., using a calm tone to convey safety and control when clients feel out of control, making lists of priorities to structure sessions).

Vignette

Visit 1 (hospital emergency department)

Because Roxanne's behavior is sometimes inappropriate, two counselors go to the ED. Counselor 1 is Roxanne's assigned counselor. The counselors' goals for this meeting are to:

- Help Roxanne leave the ED before she is arrested.
- Set up an appointment for the next day to discuss her concerns.
- Transport her back to her SRO.
- Preserve their organization's relationship with the ED.

They find Roxanne in the waiting area. When she sees the team arrive, she immediately begins insulting the ED staff, loudly complaining that no one is paying attention to her pain.

ROXANNE: That b#*%! is ignoring me! Can't you see I'm in pain? My *God!* No one here cares about anybody but themselves, God #*%! it! Maybe you can help me. Tell them I'm in pain! I'm in pain!!!

COUNSELOR 1: Roxanne…

ROXANNE: Thank *God* you're here! Oh my God, thank you. You gotta tell them I hurt! I'm hurting! My back hurts so much! They don't know what the #*%! they're doing here!

[Roxanne grabs Counselor 1's shirt. Caught off guard by this, the counselor turns his head away.]

ROXANNE: Make them pay attention to me!

> **Master Clinician Note:** Given Roxanne's history and current behavior, it may be that she was not examined carefully. Barring any clear danger to the client, it is important to avoid confronting the ED staff with this possibility at this time. Issues about Roxanne's treatment in the ED can be carefully examined away from the urgency of the moment. Moreover, Roxanne may further escalate her behavior if she senses disunity between the ED staff and her counselor. The team will address Roxanne's own behavior and desire for medication after leaving the ED, minimizing disruption and breach of privacy in the public waiting area.

COUNSELOR 2: Roxanne, listen…

[Counselor 2's calm tone and kind manner catch Roxanne's attention.]

ROXANNE: No, I'm really hurting! You gotta get me some medication, pleeeease! *You* understand. I'm a woman. I have problems. You understand. Can you help me, *please!!* Please! My back really hurts!!

COUNSELOR 2: Roxanne. Can you—

ROXANNE: [*shouting*] Let's go to another hospital! I gotta do something!

COUNSELOR 2: [*calmly but firmly*] Can you go back to the chair, please? Listen, they called us and said they can't give you medication. We'd like to get you in the van and take you home.

> **Master Clinician Note:** Counselor 2's calm, firm tone communicates safety and control, and the simple instructions help Roxanne, who feels out of control, focus and calm down. There are no easy solutions to this situation. If Roxanne had *not* de-escalated, the counselor might next have opted to give her the choice of leaving the ED to discuss further options. She may have said, for example: "You say you want to go to another hospital. Let's go outside, where we can speak more privately and discuss the options." The short walk may have allowed Roxanne to collect her thoughts away from an audience in the ED. The counselor's second option might have been to call security. Although always a potential tool for safety, using this option too hastily may have resulted in a power struggle and led to Roxanne's physical restraint and sedation, the former being highly traumatizing and the latter unintentionally colluding with her demand for medication. This would have reinforced her repeated inappropriate demands. As Roxanne engages in treatment, her providers will assess her trauma symptoms, develop an understanding of how her behavior helps her cope with these symptoms, and integrate this conceptualization into her treatment plan.

[In a quick, nonverbal exchange, the two counselors agree that Counselor 2 will take the lead in interacting with Roxanne. Their training has prepared them for just such situations. They know that if both try to interact with Roxanne, it is likely to create an environment in which Roxanne can play one counselor against the other.]

ROXANNE: What are we gonna do about this God #*%! pain?! That b#*%! isn't helping me.

COUNSELOR 2: We'll set up an appointment. Do you think you'll be ready for one tomorrow?

ROXANNE: I want some meds.

COUNSELOR 2: They aren't going to give you meds here. We already know they've made that decision.

ROXANNE: I hurt. I'm hurting. I'm *really hurting!* Please! Somebody *help* me, please!

COUNSELOR 2: Tomorrow we're going to try and take care of it. Just let me—

ROXANNE: Well, you *better*. I'm gonna sue somebody. I'm gonna sue that b#*%! over there!

COUNSELOR 2: Forget them for now. You know the last couple of times we talked to you about some options, and we can do that again tomorrow.

ROXANNE: I need something for this pain. Can you get me something tonight?

COUNSELOR 2: I can't get you something tonight.

ROXANNE: What am I gonna do, then?

COUNSELOR 2: We're going to get in the van, we'll take you home, and you can get some rest, try to sleep, and get a fresh start in the morning. All right?

ROXANNE: What time?

How To Intervene With a Client Who Is Being Disruptive in a Public Place

1. Compassionate direction can help the client disengage from the situation and calm down. Speak calmly and firmly; give simple instructions (e.g., "look at me," "please sit down").
2. Get the client out of the public place. One way to shift the client's focus is to say, "Your pain is important to us—let's go somewhere where we can talk and make a plan to deal with it the best way we can."
3. You may be tempted to agree to unrealistic requests, like a meeting at 7 a.m. It's okay to set limits by saying, "I'm not able to meet with you at 7, but I can meet with you at 8:30."
4. If you give in, one way to rectify it is to say, "Look, I know we said 7. I was feeling your pain and lost my sense of what I'm really able to do tomorrow. I can't come any earlier than 8:30." Your client may not be pleased with waiting until 8:30, but you're modeling how to handle inappropriate requests, and the client will appreciate that you are being clear about what you're able to do.

COUNSELOR 2: You name it.

ROXANNE: Seven o'clock.

[During the van ride back to her home, Roxanne tests more limits by insisting that she needs pain medication and taking off her seatbelt. The counselors stay composed, calmly telling Roxanne that they'll pull over if she won't put on her seatbelt. They give her the option of getting aspirin at a drug store, which she accepts. As Roxanne begins to calm down, she throws a cup at a counselor. Both counselors stay calm, explaining that her safety is important to them, so they can only transport her if she stops doing things like throwing cups. They say that they want to take her back home as long as she's willing to use her seatbelt and refrain from unsafe behavior. Roxanne agrees to accept the ride on those conditions.]

Master Clinician Note: Reacting with harsh confrontation or a punishing tone to provocative behavior like Roxanne's is tempting. However, the counselors understand that her personality disorder along with possible PTSD make it very difficult for her to regulate her emotions and that it is important to reinforce her sense of safety, control, and empowerment. Additionally, Roxanne has, in the past, often been successful in getting what she wants by escalating her disruptive behavior and becoming provocative. It is important that the counselors recognize the provocation as an attempt to get her needs met and refuse to be manipulated by it. The counselors believe that when Roxanne returns home, she'll buy pills on the street. They could say, "I can see that you're really hurting and I'm worried that you'll do something that may put you at risk between now and tomorrow morning. Let's talk about options." The counselors know that this suggestion is unlikely to influence her immediate choices, but planting the seed helps her develop alternative coping skills to manage her discomfort, and they convey their concern that she might use a maladaptive coping behavior. The counselors also recognize that some of the irritation, agitation, and pain that Roxanne is experiencing may be residual withdrawal symptoms. In subsequent visits, the counselors will focus on helping Roxanne increase her motivation to obtain substance abuse treatment, return to the pain management clinic, and develop coping options when her subjective experience of pain feels like it is becoming unmanageable.

Visit 2 (counselor's office)

Roxanne sleeps past her appointment, although the counselor has telephoned to wake her. When she finally arrives in the afternoon, she doesn't want to discuss her behavior at the ED, preferring instead to make demands on the counselor. The counselor's goals for this meeting are to:

- Reinforce the therapeutic relationship with Roxanne, particularly in light of their encounter in the ED the previous evening.
- Discuss her behavior at the clinic and her other options for pain management.
- Engage Roxanne in a screening process to assess for a possible substance use disorder.
- Help Roxanne understand the requirements of the SRO regarding drug use and visitors.

Roxanne arrives with a list of complaints, including not having water last night and feeling back pain. In response to the counselor's attempt to focus on her behavior at the ED, she becomes even more upset.

> **Master Clinician Note:** The counselor agreed to meet Roxanne at an early hour. When she doesn't appear, he's angry. He also expects Roxanne to be erratic and provocative in today's session, possibly leading to a nonproductive or even contentious session. He needs to prepare for the session, first, by accepting his angry feelings and, second, by carefully preparing constructive responses (e.g., supportive limit setting, keeping goal expectations modest and prioritized) before the meeting.

ROXANNE: I go 'cause I hurt and they ignored me last night! What are we gonna do about this water situation? I had to go out last night to get water, to take some more pills. There was no water. By the way, I got a letter today from public assistance telling me they're cutting off my benefits. Nothing's happening! I don't understand. Somebody here did something. Somebody's got it in for me, I just *know*.

> **Master Clinician Note:** In almost every session, Roxanne has a pattern of raising multiple issues that seem unrelated. If the counselor begins to address one of these issues, Roxanne is likely to change the subject and move to another perceived problem. It is important for the counselor to identify the most pressing issues and help Roxanne stay focused on those issues. Some strategies the counselor could use include:
>
> 1. Assessing and prioritizing problems to address.
> 2. Considering which problems, if effectively addressed, will ease the pressure of or resolve other problems.
> 3. Evaluating which problems Roxanne and the counselor can effectively address and which they cannot.
> 4. Deciding how complex problems can be broken down into several less complicated problems that can be addressed.

COUNSELOR 2: They're concerned about your behavior at your building. The housing manager called and said you're violating the visitor policy and getting into fights with your neighbor. I'm worried about your being able to stay there. If things keep going like this, I'm afraid you're going to lose your apartment.

How To Keep a Client Focused

When treating clients with many demands or problems, the following strategies may help:

- Limit session length at the outset (e.g., "we have only half an hour today").
- Create a list of the client's priorities to help you both maintain focus on treatment goals.
- Stay consistent from session to session. Stick with the treatment plan.
- Be firm but not rigid. Things will occur that dictate a need to change the treatment plan.
- Set goals that are realistic and can be accomplished in a timely manner.
- Identify realistic expectations for client behavior; recognize small successes as progress.

[The counselor decides to focus on the housing issue with Roxanne because if she does lose her housing, it will be very difficult for her to maintain the gains she has made in other areas of functioning.]

ROXANNE: I'm gonna lose my apartment if I don't get my #*%!ing benefits turned back on.

COUNSELOR 2: Well, we don't want you to lose your apartment. So, the next time or maybe the time after when you come in, bring that paperwork for your benefits, and we'll see what you and I can do about you keeping your benefits. But Roxanne, we have to look at what is going on in your apartment. Maybe we can meet—you, me, and the housing manager of your apartment—and see how we can resolve some of these problems. Do you think we could do that?

ROXANNE: That's really not gonna do anything for my pain. My back hurts, and it hurts *all the time*!

COUNSELOR 2: I agree; your pain is difficult. I hope you can get back to the pain clinic at the hospital, but right now, let's see what we can work out about keeping your housing.

ROXANNE: The only thing that helps is oxycodone. It *really* helps.

Master Clinician Note: The counselor realizes that Roxanne is not prepared to focus on any one issue except getting her drugs and that continuing to pursue issues about housing or obtaining substance abuse assessment is going to be futile. He anticipates that continuing to press Roxanne at this time will only increase her alienation and escalate her complaints. He decides to forgo more discussion at this time and wraps up the session with a summary of their visit, reminding Roxanne to bring her benefits papers when she returns for the next visit.

[This was a particularly challenging session for the counselor. Feeling overwhelmed by Roxanne's demands, the counselor knows he should seek supervision. The supervisor affirms the counselor's choice to seek assistance. His supervisor helps him assess Roxanne's problems and then structure sessions, assess Roxanne's readiness for change regarding her possible substance abuse, and identify appropriate interventions while also providing support for the counselor. The supervisor encourages the counselor to continue to address the challenges of working with Roxanne in supervision. Some of the supervisor's suggestions and insights include:

- Support Roxanne's goal to keep her housing; this keeps the door open for her to accept indicated treatment later. Offer options, but don't take responsibility for her choices. She will make her own.
- Help Roxanne increase her motivation to obtain an evaluation for substance abuse treatment.

- Use contingency management (described later in this vignette) to help her engage and stay in treatment if it is indicated. Offer incentives she relates to (e.g., clothing vouchers) for meeting objectively measurable goals that are important to her (e.g., keeping her housing by behaving appropriately in response to complaints, attending pain management for treatment of her back pain). This will help her develop internal motivation.
- Encourage Roxanne to develop coping skills for managing anger. If she becomes hostile, end the session in a compassionate, noncombative way and see her again when she's able to speak calmly.
- Help Roxanne focus during sessions by making a list with her that includes her goals, such as getting help for her pain and addressing concerns about her apartment.
- Spend the last 15 minutes of every session reviewing the items covered during the session, keeping Roxanne focused on her list of goals and ways she can demonstrate that she has reached these goals.
- Reframe her behaviors as strengths. She is skilled at reading people, focused on her own agenda, actively engaged in getting what she wants, and persistent. This will increase her sense of self-efficacy and help her see ways of shifting her behavior toward more adaptive outcomes.
- Continue noting countertransferential feelings in response to Roxanne's behaviors; seek supervision.]

Visit 3 (housing manager's office)

After meeting with his supervisor, the counselor, with the cooperation of the housing manager of Roxanne's apartment building, schedules a meeting with Roxanne, the housing manager, and himself. The manager has been confronted by other tenants who complain that Roxanne is loud and argumentative and may be using her apartment for prostitution. The housing manager notes that if Roxanne cannot be more cooperative, she is going to lose her apartment.

The counselor wants to foster a spirit of teamwork, hear firsthand about the problems Roxanne is creating, and support the housing manager in working with Roxanne to reduce the risk of losing her apartment. The counselor's goals for this meeting are to:

- Assist Roxanne in keeping her apartment; the counselor sees Roxanne's maintaining stable housing as a precondition to addressing other issues, such as pain management, substance use, and management of trauma symptoms.
- Show Roxanne that her concerns are taken seriously.

Trauma-Informed Care

Trauma-informed care is an approach to working with clients who have histories of trauma that recognizes trauma symptoms and integrates this information into treatment planning and delivery. Roxanne's counselors recognize that many of her behavioral symptoms may be a result of significant trauma in her history, and they use that recognition in helping Roxanne develop a treatment and recovery plan that incorporates mental health, substance abuse, and trauma care along with housing. One key strategy of trauma-informed care is empowerment: helping the client take responsibility for his or her own recovery and life. Observe how the clinicians, in cooperation with the housing manager, seek to empower Roxanne. For more information on trauma-informed care, see the SAMHSA-sponsored National Center for Trauma-Informed Care Web site (http://samhsa.gov/nctic/) or consult the planned TIP, *Trauma-Informed Care in Behavioral Health Services* (SAMHSA, planned h).

- Create an environment that reinforces adaptive behavior.
- Show that the service team is unified in its approach to her problems.
- Address specific issues raised by a neighbor who has complained about Roxanne's behavior.

The counselor and the housing manager agree that the housing manager will take the lead in the meeting. The counselor will step in to support Roxanne when she identifies positive changes she is willing to make regarding her housing situation.

ROXANNE: Someone stole my public assistance stuff, and I'm sure it was her, because that b#*%! is just out to get me. She has nothing good to say about me. You've gotta take care of that! She slips nasty notes under my door and threatens me for some reason. She's just got it in for me, and I've just *had it* with her!

HOUSING MANAGER: Well, she has some complaints about you too, Roxanne.

ROXANNE: What have *I* done?

HOUSING MANAGER: She says you're always having a lot of men over at your place.

ROXANNE: [*sounding superior*] I'm allowed to entertain anybody I want.

HOUSING MANAGER: Well, I need you to do some things for me; I have a job to do, Roxanne.

ROXANNE: You just do your job.

HOUSING MANAGER: Well, you're going to have to help me do my job.

ROXANNE: How? You're gonna pay me to do your job?

HOUSING MANAGER: No, this is what I want you to do: Cut down on the traffic to your room.

ROXANNE: There's nothing in the rules that says I can't have people there. I've read the rules. I know what they say. They don't say that I can't have people there.

HOUSING MANAGER: I have just told you I've had complaints from your neighbors, so I'd be willing to work with you if you're not going to—

ROXANNE: She's just got it in for me. I'm not going to say one word to that b#!*%! But I tell ya, when I catch her stealing my mail, she's gone!

How To Prepare for Joint Sessions

1. Support a spirit of teamwork among the staff members who are present: Create a tone that emphasizes that everyone is working toward the same goal.
2. Use the first minutes of the session to set boundaries for the focus of the session, being clear about the issues that will be discussed. Everyone comes to the session with a separate agenda, and things can get out of hand without clear agreement on session goals. Be sure all participants have an opportunity to state their goals.
3. Prepare all participants for the client's likely responses (e.g., coping styles): review the client's history, current issues and goals, and past behaviors in similar circumstances.

How To Manage Inappropriate Behavior

When your client becomes inappropriately seductive and oversexualized with the staff:

1. Pause and identify for yourself what he or she is doing.
2. Consider how this behavior fits with your conceptualization of the client. Inappropriate behavior is part of chaotic relationships.
3. By stepping outside the chaos and observing what is going on, you can identify the seductiveness and label it as an issue to work on in treatment.
4. It is also important to kindly and firmly limit the inappropriate behavior.
5. Use structure (e.g., a list of priorities) to help the client focus.

HOUSING MANAGER: Well, if you catch her stealing your mail, you should come tell me and I'll make a police report. What's going on with your apartment?

[Roxanne continues by listing a variety of problems with her apartment: a leaky bathtub, peeling paint, a problem with her refrigerator, a wall switch that isn't working, and a request for a new mailbox lock because she thinks her neighbor is stealing her mail. The housing manager listens carefully and takes notes of the items that need correcting. Although the housing manager does not commit to making all of the repairs immediately, he does seem to be listening carefully and taking her concerns seriously.]

HOUSING MANAGER: Anything else?

ROXANNE: Well, that's it for now. There's always something. But those are the worst now.

HOUSING MANAGER: So you need a mailbox key, a refrigerator, a new paint job, and the tub fixed.

ROXANNE: When are you gonna do it?

HOUSING MANAGER: What are you going to do for *me*?

ROXANNE: What do you mean, what am I gonna do for *you*? I don't *work* for you!

HOUSING MANAGER: What are you going to give me when I fix these things?

ROXANNE: [*a bit sarcastically*] A "Thank you very much."

HOUSING MANAGER: Now, can I tell you what I want from you?

ROXANNE: Something from me? *I've* got something. [*seductively*] You'll really enjoy it.

HOUSING MANAGER: This is exactly what I'm talking about, Roxanne. This is not appropriate. Let's talk about what we can do with the apartment.

ROXANNE: But you said I was going to have to give you something, so you set me up.

Master Clinician Note: The counselor steps in to interrupt the conflict and redirect the conversation and then steps back to let the housing manager take the lead once again.

COUNSELOR 2: Let's listen to what he would like to have you do. [*addressing the housing manager*] What is it that Roxanne can do to help with this?

HOUSING MANAGER: The main thing that will help me speed up making the repairs is if you're willing to consider not having as many people over in one evening.

ROXANNE: What do you mean, not as many people?

COUNSELOR 2: Limit her guests to just one or two in an evening?

HOUSING MANAGER: Yeah.

COUNSELOR 2: Can you do that?

ROXANNE: Yeah, I can do that.

HOUSING MANAGER: Which of your apartment problems would you like me to address first?

ROXANNE: Uh, my refrigerator.

HOUSING MANAGER: Yeah, I'm not saying I'm going to replace it. I'll replace it if it's not repairable.

ROXANNE: Okay.

HOUSING MANAGER: And we'll take care of the tub.

ROXANNE: Okay. What are you going to do about my neighbor, though?

HOUSING MANAGER: I'm going to talk to her, and I'm going to ask her not to bother you.

ROXANNE: You do that. I won't bother her, believe me. She's gotta stay away from my mail!

COUNSELOR 2: If you think that she's in your mail, will you come to me and let me handle it?

ROXANNE: Yes.

COUNSELOR 2: Okay. So, can we go look at her refrigerator now?

HOUSING MANAGER: Yeah, sure.

[The housing manager leaves the meeting to get the repairman to work on Roxanne's refrigerator. After his departure, the counselor spends a few minutes with Roxanne, supporting her for working toward resolving the problems. He also reinforces the need for Roxanne to limit visitors to her apartment and to bring complaints to the manager rather than confronting other residents directly. The counselor notes that during the entire meeting, Roxanne did not complain of pain or the need for pain pills. He does not mention this to Roxanne, but decides to wait for Roxanne to raise the issue again. He schedules the next appointment with Roxanne for later in the week at his office.

After returning to his office, the counselor calls the housing manager to express appreciation for his skillful work in the meeting, thus building teamwork.]

Visit 4 (counselor's office)

After another meeting with his supervisor, the counselor sets these goals for his next visit with Roxanne:

- Use a list to structure and prioritize the conversation.
- Help Roxanne accept medical treatment with Dr. Thomas, the program physician, who is associated with a local community health clinic. The counselor would like to use the visits with Dr. Thomas as an entry point for getting Roxanne to return to the pain clinic at the hospital, hoping that pain management may be a way to engage her into addressing her substance use.
- Identify some strategies to help Roxanne move from the precontemplation stage to the contemplation stage for addressing her substance use.

Roxanne arrives late, looking exasperated and preoccupied. She apologizes for being late and begins a rapid-fire complaint about her neighbor. The counselor helps her focus on making a list of priorities for them to work on.

COUNSELOR 2: What I'd like to do is talk about the most important things for you *right now*. There are so many things going on. What's the most important thing for us to try to help you with right now?

ROXANNE: What do you mean, "help?" I mean, there's all kinds of things going on.

COUNSELOR 2: Yes, there are a lot of things. Let's see if we can decide which are most important to focus on right now.

ROXANNE: So, you want me to choose which is the most important thing?

COUNSELOR 2: Yeah.

ROXANNE: My back.

COUNSELOR 2: Okay, so we want to concentrate on…

ROXANNE: Then my neighbor.

COUNSELOR 2: Your neighbor?

ROXANNE: My public assistance is still cut off. I got this leaky faucet.

How To Use Lists To Keep Clients Focused

1. Ask, "What are the three most important things for you? It helps me to make a list of what's important." Lists create structure and help the counselor and client stay on the same page.
2. Help the client prioritize his or her most important concerns.
3. When the client veers off, the counselor can say, "Well that's not on the list. Let's talk about your list because those are the most important things. If they aren't the most important, we can change the list."
4. Agree on the time needed for each item to increase structure. "How long do you think we need to handle this item? Also, I need to speak with you about a few things, so I'll need 15 minutes at the end to talk about… "

COUNSELOR 2: So, there are four things.

ROXANNE: I've got this guy after me—I'm real worried about that. And my back.

[The counselor and Roxanne settle on three issues to focus on today: her pain, the man who is after her, and relationships with other tenants at the SRO housing facility.]

COUNSELOR 2: All right, so let's talk first about getting you an appointment with Dr. Thomas about your pain.

ROXANNE: I don't like him.

COUNSELOR 2: He's the physician we can use in this program.

ROXANNE: Can't you find me somebody else? Can't you find me a woman doctor?

COUNSELOR 2: Sorry, we don't have a woman doctor. I understand that you would rather see a woman doctor, but Dr. Thomas is the only doctor assigned to this program. If you see Dr. Thomas and then still want to see another doctor who is female, I can see if we can arrange a referral.

Master Clinician Note: The counselor thinks that Roxanne wants another physician because Dr. Thomas has not given her pain pills on past visits, but he is sensitive to the possibility that Roxanne may want to see a female physician because of a history of sexual traumatization. He doesn't explore that issue right now with Roxanne, but he makes a note to explore it in the future with her.

ROXANNE: [*sighing*] Oh, all right. But he doesn't give me pills for my pain.

COUNSELOR 2: Roxanne, I understand that your pain is a real difficulty for you. But the drugs you want are very addictive, and I don't think you are going to find doctors who will consistently give you the drugs you want.

ROXANNE: No, I need it. It takes away the *pain*. I'm not addicted to it.

COUNSELOR 2: I know you don't think you are addicted. But we need to find some other ways to manage your pain and your drug use.

ROXANNE: Yes. I'm not addicted to it, I mean… I just need something for the pain. I mean, look, if I can't get oxies, I'll buy something else off the street.

COUNSELOR 2: They help?

ROXANNE: Yeah, because the pills take away the *pain*.

Master Clinician Note: The counselor is preparing Roxanne to have modest but substantive expectations of the consultation with Dr. Thomas. By acknowledging Roxanne's pain and eliciting the relationship between Roxanne's pain and her drug-seeking behavior, the counselor enhances rapport and identifies one of Roxanne's needs. The counselor also demonstrates acceptance that Roxanne is in the precontemplation stage of change for addressing her drug-seeking behavior and the contemplation stage for exploring alternatives to oxycodone for managing her pain.

COUNSELOR 2: You can talk to Dr. Thomas about what you might do to manage the pain. You and he can make a plan for what you can do about the pain.

[The counselor raises the issues of the man who is "after" Roxanne and her relationship with the other tenants in her housing, but Roxanne shows little interest in addressing either issue now.]

> **Master Clinician Note:** The counselor suspects that Roxanne's complaints have diminished as a result of her feeling understood and having her needs recognized. With another client at a more advanced stage of change, the counselor might ask if the client feels more comfortable or less distressed than when she came in, and then proceed to explore what happened to initiate the change. But with Roxanne, the counselor suspects this intervention might just invite Roxanne to begin focusing on all that is going wrong in her life and lead her to feel more agitated.

[Roxanne lets the counselor schedule the appointment, and the counselor agrees to talk to Dr. Thomas about attending to Roxanne's concerns. He will also ask Dr. Thomas to consider talking with Roxanne about the pain management clinic and encourage her to accept a referral.

Besides the meeting with Dr. Thomas, Roxanne agrees to continue to bring her concerns about the apartment to the housing manager and not the other residents. Roxanne has a letter from public assistance that she doesn't understand, so she will bring it with her when she goes to see Dr. Thomas, and the counselor can help her with it. This contingency makes it more likely that Roxanne will show up for her appointment.]

Visit 5 (counselor's office)

The counselor speaks with his supervisor about his countertransference with Roxanne and his concerns about forming a treatment contract. They agree on specific goals for the counselor's next visit with Roxanne, which include:

- Remaining consistent with the list of priorities.
- Following up on Roxanne's visit to Dr. Thomas.
- Developing a contingency management program for Roxanne that will support her continuing in treatment and reinforcing changes she has made in pain reduction, drug use, interpersonal relationships, and continuing in treatment.
- Expecting Roxanne to present urgent issues and responding by maintaining a firm but flexible focus on treatment goals.
- Helping her form reasonable expectations of what can be accomplished; keeping the list manageable.

Roxanne reports that, as a result of seeing Dr. Thomas, she's scheduled for a magnetic resonance imaging scan (MRI) of her back and asks what an MRI is. The counselor explains, and Roxanne expresses disappointment that the doctor gave her no medication. She also agreed to schedule a visit to the pain clinic to reenter the pain management program, part of which is a comprehensive evaluation for substance abuse, brief intervention, and referral for treatment, if needed.

ROXANNE: I'm really pissed off 'cause I'm still hurting, and he didn't give me anything.

COUNSELOR 2: Well, I'm really impressed by the fact that you're hurting and yet you came to meet with me, and you worked to get some things done in the apartment.

ROXANNE: My bathtub still isn't fixed.

COUNSELOR 2: Some things are taken care of.

ROXANNE: Yeah, he gave me a new key. I got that.

COUNSELOR 2: Good. I think when you focus, you get things done and people respond to you. That is a real strength that you have.

Master Clinician Note: This intervention identifies and positively reinforces Roxanne's adaptive behavior, thus building her self-confidence and esteem.

ROXANNE: I guess… people just keep bothering me.

COUNSELOR 2: Well, look. I read over your letter from public assistance. It's just a confirmation of your status. Your status hasn't changed. I can be a witness to that.

ROXANNE: What happened?

COUNSELOR 2: It's just a routine evaluation to see whether you're eligible to have continued assistance. You have to sign this to confirm it and I can sign off on it.

ROXANNE: [*after reading the document*] Where do I sign?

COUNSELOR 2: Right here. [*Roxanne signs the document.*] Good. I'll sign as a witness.

ROXANNE: Can I get a copy of that?

COUNSELOR 2: Absolutely. So, you've shown up for the appointments with the housing manager and Dr. Thomas, and you brought your letter as I asked, so I think you're really making some progress here.

ROXANNE: My *pain* is still there, though.

Master Clinician Note: The counselor is participating in a pilot program in the agency to use a newly developed cognitive–behavioral strategy, contingency management, with a few selected clients. Contingency management reinforces positive behaviors toward treatment goals by rewarding the client with vouchers for items that most people would like. Rewards might include special recognitions or program benefits, such as additional hours away from the treatment program. The rewards need to be tied to specific, identifiable, clearly measurable goals, such as clean drug screens, attendance at self-help meetings, and consistent treatment program attendance. Contingency management is generally implemented in settings with a number of clients participating. In this vignette, contingency management is used with just one client. Contingency management is often used in concert with cognitive–behavioral therapy. For more information on contingency management, refer to SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP). Contingency management is also a term sometimes used in housing services, where contingencies, such as staying abstinent, are a condition for housing.

[The counselor briefly explains the contingency management program to Roxanne in terms of rewarding positive, objectively measurable steps toward treatment goals. Roxanne seems quite interested in obtaining vouchers or coupons for products that she might not otherwise be able to purchase.]

COUNSELOR 2: I want to give you a coupon because you kept your appointments with the doctor and the housing manager. I've got a voucher that will get you a free hair appointment. How would you like that?

ROXANNE: I'd like that. Thank you.

COUNSELOR 2: Okay. Next week, if you keep doing well and I get no calls from the housing manager or from the ED, you'll get a voucher for Interfaith Clothing Closet to get some outfits. How's that sound?

ROXANNE: *Now* what do I have to do?

COUNSELOR 2: I don't get any calls that you've been into the ED.

ROXANNE: What if I'm *sick*?

COUNSELOR 2: Well, you're working with Dr. Thomas. You're having an MRI next week, so we have a plan that you're working on. If you get sick in the meantime, call Dr. Thomas.

ROXANNE: What if I have a pain in my back again, like a stabbing pain, and I can't stand it anymore and it's, like, in the middle of the night, and Dr. Thomas is not available?

COUNSELOR 2: If something happens and you have an emergency, then you can go to the emergency room. But if you're going to ask for oxycodone, that wouldn't be following our agreement.

ROXANNE: So I can go to the emergency room, but I can't ask for any pills?

COUNSELOR 2: Right.

ROXANNE: Okay.

[The counselor educates Roxanne about how stress and pain are related, and how there may be other ways to address the pain that may be more helpful than pills. Roxanne refuses to consider going to the pain clinic and steers the conversation back to the emergency department.]

ROXANNE: [*dismissive*] Well, I just know what's gonna happen. I'm gonna wake up in the middle of the night, and I'm gonna be in pain, and I'm not gonna be able to go back to sleep, and I'm not gonna be able to get help because you're telling me I can't go to the emergency room and get some oxies.

COUNSELOR 2: I didn't say you couldn't go to the ED. I said it's not consistent with our agreement if you go to the ED and try to get oxycodone.

ROXANNE: I'm gonna go to the emergency room to get some relief or something.

COUNSELOR 2: So that will be our understanding. If the ED tells me you were requesting oxycodone again, I won't give you the voucher for the Clothing Closet. Do we agree about the voucher and the ED?

ROXANNE: [*tolerant*] I suppose.

COUNSELOR 2: Okay. Well, I think we have everything set up. Now, I'd like for us to put our agreement in writing. Would you like to have that? I promised you a voucher for the Clothing Closet. You could go there and pick two outfits, but in return, the understanding is that you won't go to the ED and ask for oxycodone, and you'll follow through with your appointment with Dr. Thomas next week.

ROXANNE: [*a little confrontational*] And if I don't sign?

COUNSELOR 2: We won't have an agreement, and you won't get a chance to get a couple of new outfits. This is how we both understand what we're agreeing to. What have you got to lose?

[Roxanne challenges the counselor; his calm response enables her to go along with the plan.]

ROXANNE: Can I get some shoes with that?

COUNSELOR 2: I don't know whether they have shoes, but the voucher gets you a couple of outfits. If the outfits include shoes, you could look at shoes.

ROXANNE: Okay.

Master Clinician Note: Committing the plan to paper is a good idea for Roxanne; she'll have it to help her remember what she is supposed to do in order to get the clothing voucher. It also assures her that as long as she follows through, the counselor will, too. Some clients may not need written cues, but when structure and/or ability to remember details are issues for clients, it is a good idea to put agreements in writing.

Summary

The counselor now has the tools to respond effectively when Roxanne is demanding and chaotic. He understands that he can't realistically meet all her needs and doesn't have to. Clinical supervision helped him become aware of his countertransference (i.e., feeling angry, weary, manipulated, challenged, and provoked) and develop ways to manage it so he can respond to Roxanne calmly yet firmly. This approach helps her form a plan to keep her housing, address her back pain, and consider alternatives to oxycodone.

When Roxanne was in the ED, she was in the precontemplation stage of change for finding alternative ways to manage pain, substance use, high-risk behavior, provocative behavior, and housing problems. The counselor's respectful and empowering intensive-care approach (goal setting and reinforcement of appropriate behaviors) has moved Roxanne into the preparation stage for alternatives to managing pain and the action stage for keeping her home and changing problem behaviors. As she succeeds in managing pain and maintaining housing, she may be more motivated to engage in substance abuse treatment.

Long-term goals for working with Roxanne include:
- Continuing to support and reinforce behavior that allows her to maintain her housing.
- Continuing to pursue pain management.
- Obtaining treatment for her substance use, if warranted.
- Increasing motivation to engage in services by exploring and resolving ambivalence; creating a plan that she is confident she can make work.
- Connecting her with acceptable recovery supports (e.g., mutual support groups, faith-based supports).

Vignette 4—Troy

Overview

Troy is in the intensive care phase of homelessness rehabilitation. This vignette demonstrates approaches and techniques for preventing homelessness and engaging the client in substance abuse treatment.

Troy is a 32-year-old single father who is dependent on alcohol and marijuana. He had one brief episode of homelessness in his early twenties, was in substance abuse treatment 2 years ago, and attended Alcoholics Anonymous (AA) regularly until about a year ago. He relapsed about 6 months ago and lost his roofing job. Until his relapse, he had been abstinent for 18 months. The relapse seems to have been triggered by his wife leaving the family, financial difficulties, and dropping out of AA. He says he quit attending AA because he could not arrange child care for his sons, ages 6 and 8. He got custody of his children 8 months ago, after his wife left.

He lacks good childcare, parenting, and time management skills and is easily overwhelmed. When he becomes overwhelmed, he tends to "shut down" and withdraw from others, which increases the environmental stressors. He has food stamps and public assistance but can't cover his rent. Troy has a Section 8 voucher and is afraid that he is about to lose his apartment. For more information on Section 8 housing assistance, see the note on page 103.

Some of the stress-related symptoms he currently experiences include:
- Difficulty staying focused on one issue; when he tries to focus on one issue, he tends to become overwhelmed.
- Lack of energy and no desire to take on problems that really need to be addressed.
- Difficulty remembering things, which leads to missed appointments.
- Feeling like he has so many problems that he doesn't know where to start.

Troy remembered that his old behavioral health counselor was very helpful to him, so he called to see if the counselor could help him with his housing.

Setting

The counselor works in a community-based, multiservice substance abuse treatment organization. Some of the program staff members specialize in housing and employment assistance.

Learning Objectives

- Adapt counseling strategies to unique client characteristics and circumstances.

- Coordinate treatment and prevention activities and resources that suit client needs and preferences.
- Understand the interaction of co-occurring substance use and mental disorders with homelessness.
- Work with others as part of a team.

Strategies and Techniques

- Homelessness prevention
- Cognitive restructuring
- Working with persons who have co-occurring substance use and mental disorders and are homeless
- Interventions for substance abuse relapse

Counselor Skills and Attitudes

- Assess basic life skills and functioning.
- Recognize and address underlying issues that may impede treatment progress.
- Respond appropriately to the client's environmental stressors, employment situation, and childcare responsibilities.
- Accept relapse as an opportunity for positive change.

Vignette

Visit 1 (counselor's office)

The counselor has not seen Troy for 10 months and begins the first session with the following goals:

- Reestablish the working relationship.
- Identify the concerns that have prompted Troy to seek treatment.
- Understand the circumstances for Troy's relapse.

Troy arrives at the session looking down in the dumps, tired, and distracted. His speech is soft, and he is slow to respond to the counselor's questions. He appears to be having difficulty concentrating.

COUNSELOR: Tell me about why you wanted to see me.

TROY: Well, I dunno. Because I'm using a lot of weed and stuff. I been using it for a while; a lot of stuff's going down. I'm behind on the rent and it's really hard to keep up. It takes the edge off, you know?

COUNSELOR: Last time you were in, we spoke of coping with stress. Have you been using those skills?

TROY: A little bit. I've been trying to keep up with my kids and stuff.

COUNSELOR: All right.

TROY: I put the kids to bed at 9, and it's my time after that, you know.

COUNSELOR: Around what time do you go to bed?

TROY: It depends. Midnight, 1 o'clock. Sometimes the guys are over and we stay up a little bit late, you know, smoke a little, drink a little. But I'm so *tired* when I get up in the morning.

COUNSELOR: You're really tired in the morning.

TROY: [*affect is somewhat flat*] I have to get them to school. It's good that I do that, you know? Then I go home and… I messed up a couple months ago. I go to sleep sometimes after I drop them off, and I didn't show up to work, and now it don't even matter to me if I work. I got enough with the boys.

[Troy and the counselor spend a few minutes talking about his wife abandoning the family, his dropping out of AA, his relapse, and the loss of his job. Troy thinks his most pressing problem right now is the possibility of losing his home.]

COUNSELOR: Yeah, having children can be challenging—it's a new life that you have, right?

TROY: Yeah, I guess so. It just gets the better of me. I didn't know it was going to be like this.

COUNSELOR: I remember when you were in treatment; we talked in group one night about your fear that your wife might leave if you got clean. As I recall, you thought you were definitely the better parent for the boys and that, if she left, if you got custody of them, it might be good for everyone.

Master Clinician Note: The counselor empathizes with the challenges of single parenthood and reminds Troy how proud and excited he was to get his boys. This helps Troy to decrease negative self-assessment and increase his confidence in his ability to make a change. A key treatment effort in early recovery is to help clients increase self-esteem, improve self-confidence, and learn to evaluate the impact of their actions before they act.

TROY: Maybe. I just gotta get back to my house to just see the kids, I dunno.

COUNSELOR: Where are your kids now? In school?

TROY: They should be getting home any minute. I gotta leave here in just a few minutes.

COUNSELOR: Okay. I can see that you are under pressure to be there when they get home. Can you give me at least 5 minutes? Let's list what we talked about. You're worried about losing your apartment, it's hard managing the kids, and you've relapsed—is that correct?

TROY: Yeah, like, it's just not happening for me now. Sometimes I guess I get to the point where I just say, #*%! it. And, maybe that's why I smoke and I been drinkin'.

Master Clinician Note: The counselor empathically reflects Troy feeling overwhelmed, letting Troy open up more about feelings of hopelessness, irritability, and the role of substance abuse. Taking time to gather more information and develop rapport with the client before working on the problems the client and counselor have identified decreases client resistance to change.

How To Work With a Client Who Is Overwhelmed

Once you recognize that your client is overwhelmed with life problems or with the information you've shared in a counseling session, change your expectations for what you can accomplish in sessions until he or she is doing better:

1. Keep your sessions short (15–30 minutes).
2. Don't overload the client with information or tasks. Have realistic expectations based on the client's abilities.
3. Keep the information you provide brief; speak in simple, short sentences.
4. Offer assistance with accomplishing a task if the client isn't able to do it independently.
5. Create a list of urgent, important tasks; work to address those as the client is able.
6. Schedule brief sessions often during the week until the urgent, important tasks are done.
7. Monitor the client's body language, facial expressions, and responses for signs of overload. Offer to take a break or offer water to help the client be able to continue and feel understood.

COUNSELOR: So let's put that on the list of things we need to work on: the drinking and the weed, getting back into your AA program. We need to look into some emergency housing support until you can get back on your feet. Do you have any income now?

TROY: My brother sometimes has a little work for me; he's a contractor. But, you know, nobody is working in construction these days. So I hardly get enough to feed us.

COUNSELOR: Okay. Do you agree that these are the things we need to work on first: getting clean, going back to AA, getting you emergency housing support, and getting back to work?

TROY: Yeah. Well, I really gotta get out of here.

COUNSELOR: So, real quick, did you talk to your Section 8 representative?

TROY: Uh…nah.

COUNSELOR: Okay. Here's the representative's name and number; call her and say that you lost your job. They'll recertify your income, which will lower the rent you have to pay. [*The counselor writes down Sherri's phone number and a note reminding Troy to explain that he's lost his job.*] She'll be there until 6 tonight.

TROY: Uh-huh.

COUNSELOR: We can work together to help ensure that you won't lose your home. I have an

A Note on Section 8 Housing

Section 8 Housing is a voucher program funded by HUD. It assists very low income families in obtaining decent and safe housing in the private housing market. Once they are deemed eligible, participants find their own rental housing in their communities. HUD (through its designee in each State) then pays the landlord the difference between a specific amount (generally 30 percent of the of the tenant's adjusted income) and the fair market rent of the housing unit. Eligibility for participation is determined by the household's gross income, which generally may not exceed 50 percent of the median income of the county in which the family resides. Special programs are available for families with disabilities and to reunify families with children placed in foster care due to inadequate family housing. Involvement in drug-related or violent criminal activity is grounds for loss of Section 8 housing.

Source: HUD, n.d.

appointment available tomorrow at 11:30 if you'd like to come back.

TROY: I'll come tomorrow.

> **Master Clinician Note:** Troy has made some progress on his own getting food stamps, public assistance, and setting up an appointment for the visit today. The counselor recognizes these steps as strengths and hopes to build on Troy's ability to mobilize to get him back to AA and to help him focus on staying abstinent, developing stronger parenting skills, and getting a job. If the counselor gives him too much to do, Troy will feel overwhelmed and spiral downward, so he doesn't push these issues in the first visit. The two most pressing problems—from the counselor's perspective—are helping Troy regain abstinence and maintain his housing. Without abstinence, it will be challenging for Troy to attain the other goals of improving his parenting skills and getting a stable job. Without stable housing, the counselor suspects it will be difficult for Troy to maintain abstinence. He is also concerned about Troy's level of depression and decides to talk with him on his next visit about consulting with the staff psychiatrist.

[After the first meeting with Troy, the counselor follows up with the Section 8 staff, explaining Troy's concern about losing his housing due to unemployment and mentioning that Troy now has custody of his boys. The counselor and the Section 8 representative agree to work together to help Troy recertify his current rent, access a local rental assistance program to help pay his back rent, and engage in substance abuse treatment.]

Visit 2 (hallway outside counselor's office)

Troy doesn't make his 11:30 a.m. session, but shows up later on in the lobby. The counselor is between sessions with clients, so he talks to Troy in the hallway for a couple of minutes. Troy vaguely

How To Handle Late-Shows and Missed Appointments

How you address late-shows and missed appointments depends in part on the client's ability to plan and organize sufficiently to arrive on time:

1. If this is the client's first late-show or no-show, consider whether memory or concentration problems may exist that make it difficult for the client to remember appointments and arrive on time.
2. In the absence of cognitive problems, explain the importance of punctuality. Don't take the client into your office to negotiate; don't go out of your way to extend session time or reschedule (remove positive reinforcement). You may also give the client an appointment card, express regret that the client missed the appointment, and focus on what will be accomplished in the next visit.
3. If the client has cognitive problems, ask him or her to explain the tardiness and schedule another appointment. Don't take the client into your office to negotiate. Offer an appointment card to be kept in a wallet, or suggest putting it on the refrigerator.
4. If this is not the client's first late-show or missed appointment, and the client is tentatively engaged in services (e.g., client is chronically homeless, client's willingness to engage in services is itself a significant accomplishment), it may be unrealistic to expect punctuality. One effective approach that reinforces showing up is to allow the client to walk in and wait for the next available appointment.
5. If the client has been late or missed other appointments, but has shown the ability to be on time, then lateness or missed appointments may be a way of demonstrating ambivalence about the counseling process. Explore this briefly, as he or she walks in or calls, to enhance the relationship and make the client more likely to return. You can also express regret that the client missed the meeting and focus on what will be accomplished in the next visit.

remembered that he had an appointment but wasn't sure what time it was supposed to be—another indication of his difficulty with memory and his inability to focus. The counselor says there's an opening at 2:00 p.m. if he wants to wait. Troy agrees, and the counselor asks if he called the Section 8 representative. Troy hasn't, so he tells him to ask the receptionist to let him call while he's waiting. Troy finds it helpful to have this specific task to do while he's waiting.

The counselor meets with Troy at 2:00 p.m., but Troy announces that he can stay for only 15 minutes because he has to get his kids. The counselor's goals for these 15 minutes are to:

- Verify that Troy called the Section 8 staff and is no longer at immediate risk of losing his housing.
- Focus on connecting Troy with resources for getting clean and sober.
- Get Troy's cooperation in scheduling a psychiatric consultation.

COUNSELOR: So, what did Sherri say?

TROY: Sherri said it's all right. She gave me some information about a program I could contact for help paying the back rent. She did mention something about wanting me to stay in treatment, though.

COUNSELOR: Right. She said that you need to show that you're working on a plan for abstinence that'll help you keep your housing. You did a great job working with her; you must feel pretty good about that.

TROY: Yeah, okay.

COUNSELOR: So that piece is taken care of. There are a couple of things I want to talk to you about. First, I need you here on time for our meetings. We were scheduled for 11:30 today.

> **Master Clinician Note:** In situations when a counselor must rapidly change gears and abridge the content of the session (starting late and/or ending early), it is necessary to select simple priorities that can be accomplished in the time allowed. It is important to be clear with the client that the agenda is reduced specifically because of time constraints.

TROY: Well, you know, I got the kids to school, came back, had some stuff to do. I was tired.

COUNSELOR: What kind of stuff did you have to do?

TROY: I needed to sort of catch up on some sleep, and then I had some business to do.

COUNSELOR: You're sleeping more in the daytime.

TROY: You know, I've been sleeping a good bit. I gotta catch up on it sometime.

COUNSELOR: Sounds like you're exhausted. It's hard to get things done with a lot on your plate.

TROY: Uh-huh. I got a call from Jimmy's teacher. He's been getting to school late and they're talking about some meeting. She mentioned calling child welfare, and I gotta get out of here to pick them up. They get out at 2:45.

COUNSELOR: You sound worried. You're starting to get your life back together and be a good parent, and I can see you're very concerned about getting them on time. Can we spend 5 minutes going over a few things, and we'll get you out of here? I want to get back to that child welfare issue for just a minute.

TROY: Okay.

COUNSELOR: Okay. Well, we've got to make sure you keep your housing. That's a big priority. The other thing I think is important is your getting clean again.

TROY: Uh-huh. Well, I haven't used now in a couple of days. I haven't slept worth a damn, but other than that, it hasn't been too hard.

COUNSELOR: Okay. What do you need to keep on staying clean?

TROY: Well, I just need to keep on. I'll keep on seeing you, if you want. I gotta keep people out of the house after the boys go to bed. That's when it gets lonely, and I'm tired, and people drop over.

COUNSELOR: I want us to talk more about this, but I know you need to leave in just a minute, so I want to get back to the child welfare issue. When do you meet with the teacher?

> **Master Clinician Note:** The counselor would like to continue solving problems and building strengths with Troy to help him stay abstinent, but he recognizes that Troy has only a few more minutes left. He wants to return to the issue Troy raised of child welfare being contacted about his kids. The counselor also decides to forgo the issue of psychiatric consultation. He doesn't want to raise another issue, which might overload Troy. He respects Troy's need to get to the school on time and doesn't want to end the session on a possibly contentious note, should Troy decline to get the psychiatric consultation.

TROY: [*seems frightened*] Well, I guess 3 o'clock. I don't know what's going to happen.

COUNSELOR: You seem kind of frightened about what that meeting is about.

TROY: Yeah.

COUNSELOR: She may discuss the importance of them arriving on time or other things. I'll support you as much as I can. Call me if you want to talk about the meeting before our next session.

TROY: Okay.

Visit 3 (counselor's office)

The counselor has the following goals for this session with Troy:

- Have Troy accept a referral to the staff psychiatrist for evaluation of potential depression.
- Support Troy's abstinence and help him build strengths to continue to stay clean.
- Support Troy in taking action on behalf of his sons—for instance, by attending meetings at the school.

How To Manage the Stress of Seeing Clients Who Have Multiple Problems

Counselors have many responsibilities during and between sessions. It's frustrating to work with a client who has urgent problems and fails to show up for appointments or follow through with assignments. It's even more stressful when children are involved. How do you address these needs and avoid burnout?

1. Know the system and resources currently available in your area.
2. Help the client get access to these resources quickly.
3. Remember that you help clients handle urgent and important issues, but you're not responsible for their choices.
4. Resist the urge to rescue the client from his or her emergency and/or feelings of being overwhelmed; attempt to respond concretely to what is presented as an urgent need.
5. Remember that helping the client prioritize multiple needs is an important part of the work. Help the client create a list of the urgent, important things that need to be done and prioritize them.
6. Identify teammates who should be brought in (e.g., psychiatrist, Section 8 representative, child-care specialist).
7. Seek supervision frequently.

Troy arrives for the session on time. He still feels overwhelmed, very tired, and doesn't have much motivation to look for a job, but now has 7 consecutive days of abstinence. The session begins with Troy describing the meeting with the teacher and assistant principal of the school. The school authorities had not contacted child welfare but stressed that if the boys continued to act out at school and didn't arrive on time, they would have to take some action on behalf of the boys. The counselor supports Troy in staying clean and in addressing the needs of his sons. The counselor then decides to raise the issue of the psychiatric consultation to rule out depression.

COUNSELOR: Troy, I'm concerned that you seem tired all the time, overwhelmed, don't have much energy for doing things, and are having trouble concentrating. I think it would be good if we could get some consultation on whether or not you are depressed, and if so, what we can do about it. So, I'm wondering if we could schedule an appointment for you with Dr. Moore, our psychiatrist, to have you checked out for depression.

TROY: [*seems a bit helpless in attitude*] Yeah, I don't know. I don't wanna go see Dr. Moore. A friend of mine, when she went to see the psychiatrist, they took away her kids.

Working With Clients Who Are Homeless and Have Co-Occurring Disorders

A wide range of substance use and mental disorders can co-occur with homelessness. In most cases, homelessness makes treatment of and recovery from mental and substance use disorders more problematic, and the co-occurrence of substance use and mental disorders limits the person's ability to address critical life problems such as homelessness. It is imperative to treat all three conditions—substance use disorders, mental illness, and homelessness—concurrently using an integrated approach. For more information on the impact of CODs and homelessness, see SAMHSA's Homelessness Resource Center Web site (http://homeless.samhsa.gov/channel/co-occurring-disorders-457.aspx) and the SAMHSA Web site's section on CODs (http://www.samhsa.gov/co-occurring/).

In the following sessions, observe how the counselor and Troy work together to obtain a psychiatric evaluation of Troy's depression, implement treatment for this condition, support his recent abstinence, continue his attendance at AA, and help him maintain secure permanent housing through the Section 8 housing program.

Master Clinician Note: The counselor resists assuring Troy that meeting with the psychiatrist won't cause his kids to be taken away. It is important that the counselor never promise outcomes that are out of his control. The counselor can support the client (as shown here) to take constructive action to obtain a positive outcome.

COUNSELOR: I know you're reluctant to see Dr. Moore, but I'm concerned about how stressed you are. This may affect keeping your home and your kids. Meeting with Dr. Moore could help with that.

TROY: Yeah. Okay. When do I need to go?

COUNSELOR: I'd like to get you in as soon as possible. I'll call and see if there's anything on Monday morning or, if not, as soon as possible. Okay?

TROY. All right. When will I know?

COUNSELOR: I'll call now. Give me a couple more minutes.

[The counselor calls and arranges the psychiatric consultation for the following Tuesday morning at 10 a.m. After passing along the information to Troy, he engages Troy in problem-solving about staying abstinent, not having friends over late at night, not being around people who are using, being especially careful during times when he is feeling stressed or hopeless, and particularly, going to AA again. Troy engages in the problem-solving efforts with the counselor, and the counselor helps Troy identify strengths to address each of these issues. He is reluctant to return to AA; he says he quit going because his sponsor was putting too much pressure on him to complete his work on the program steps and because his best friend in the program had "gone out," which Troy found really discouraging. He did agree to a noon meeting later in the week, while his boys were in school. Troy also agreed to ask his mom, who lives in the neighborhood, to babysit while he attends a meeting on Saturday night. The counselor and Troy talked about how he would respond if he ran into his program sponsor, and they developed several options for this scenario.

The counselor continues to be sensitive to Troy's potential for becoming overwhelmed with too many issues and defers other issues (parenting, employment) until future sessions.

In closing, he reinforces Troy's assignments of not being around people who are using, not staying up late at night (even if he is not sleepy), staying abstinent, and attending AA. Together, they make a list of things Troy is to do and behaviors that will make it easier to accomplish them.]

How To Use Assignments Between Sessions

Assignments between sessions are a useful tool in counseling. They help learning carry over from the session into daily life and put what has been talked about in the session into action. Assignments also make change a part not just of counseling, but of everyday life, and they keep change as an "up-front" activity in the client's mind. When giving assignments, it is useful to:

1. Make sure the tasks are attainable in the time period of the assignment and, to the extent possible, can be repeated several times during the assignment period.
2. Try not to overload the client with too much to do, so the task does not seem overwhelming.
3. Make tasks behaviorally specific and measurable, a "to-do" rather than a "not-to-do" list.
4. Have clients record their successes and difficulties in achieving the tasks.

Visit 4 (counselor's office)

The counselor's goals for this session are to:

- Follow up on Troy's psychiatric consultation.
- Follow up on how abstinence is progressing.
- Check on how Troy is doing with his sons.
- Ask Troy about his plans to resume employment.

Troy arrives on time and looks somewhat less distressed and tired than he has on previous visits. He reports that his visit with the psychiatrist went well and that he liked Dr. Moore. The doctor had already reported to the counselor that he thought Troy's difficulties in focusing on tasks, not sleeping, feeling overwhelmed, and not thinking clearly were more a function of stress and alcohol and drug use than depression. He did not recommend medication but suggested that he would be glad to reevaluate Troy if he continued to have difficulties in thinking, feeling overwhelmed, or completing tasks. For more information on depression and substance abuse treatment, see TIP 48, *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery* (CSAT, 2008). The session continues as Troy talks about a meeting with the teacher of his 8-year-old son, Jimmy.

TROY: I had another meeting with Jimmy's teacher.

COUNSELOR: How did that go?

TROY: Well, he's having some anger problems in school, and he's been getting there late. Actually, both of them are getting there late.

COUNSELOR: Tell me about that.

TROY: Well, they take a long time to get out of the house. They aren't exactly cooperative all the time, you know? It's hard to pull 'em out of bed in the morning; I oversleep a little bit myself.

COUNSELOR: Okay.

TROY: I talked to Dr. Moore a little bit about it, and he said that maybe you guys could help.

COUNSELOR: There are some things we can do to help. For example, you said sometimes you guys oversleep. We can work out a better way to manage that.

TROY: Okay.

COUNSELOR: What time are they supposed to be in school?

TROY: They gotta get there at 8:30.

COUNSELOR: Okay, 8:30. What time were you getting them up when they were getting there late?

TROY: I don't know. I'd try to get them up around 7, but they'd get up at 8 or so.

COUNSELOR: It does take them a while to get ready for school, and they have to be there at 8:30. How far is school from your home?

TROY: About 15 minutes.

COUNSELOR: 15 minutes. So, you're going to need to have at least 15 minutes to get them to school. What else do you do in the morning before leaving for school?

TROY: Well, they eat breakfast, usually cereal. I try to get them up around 6:30 or 7.

> **Master Clinician Note:** The counselor's technique is called cognitive structuring. He uses questions to model and encourage problem-solving about how Troy can more satisfactorily manage his time. The counselor also distinguishes Troy's intention (waking at 7:00 a.m.) from the reality (waking at 8:00 a.m.).

COUNSELOR: So let's say you get them up at 7:00. You need 15 minutes to get to school, so that leaves an hour and 15 minutes to dress and feed them. Can you do that?

TROY: I can do it.

COUNSELOR: So, can we make a plan for that? Today is Wednesday, so for 2 more days of school—

[The counselor writes up a schedule for Troy to follow in the morning. Troy reads it and agrees that he will try it out. Troy then changes the subject to his kids.]

TROY: I get a real hassle from the boys. They fight me, and they fight each other.

COUNSELOR: What do you think they need?

TROY: Oh, I don't know. I guess I fought with my brothers every day when I was a kid, too.

[The counselor continues to explore the issue of the children's behavior with Troy, and they decide that if things don't get better in a month or if things get worse in the interim, they'll look into counseling options for the boys. The counselor is reluctant to jump right into seeking counseling for the boys, expecting that things might get better if Troy stays abstinent and the home situation stabilizes.]

COUNSELOR: Troy, I would like to raise the possibility with you of having the boys participate in some after-school activities at the Boy's Club right down the street from our center. They have a bunch of good programs, including sports, helping them with homework, and giving them some time to socialize and play with other kids. Plus, it would give you some extra time away from having to watch the boys to get some stuff done. So, I'm wondering if you would be willing to drop by there and see what is available that might be right for your boys and consider it.

TROY: Well, I could do that. I know where it is; I used to walk by it every day. I never knew what they did in there, other than play basketball.

COUNSELOR: Well, actually, they do a lot of things, and some might be helpful to you and to your boys.

TROY: Okay, I'll look into it.

Brief Strategic Family Therapy

If the children continue to show behavioral problems in school, the counselor might consider adapting an evidence-based practice, brief strategic family therapy (BSFT). Although Troy's sons are a bit younger than the typical age when BSFT is applied, it might prove helpful.

BSFT is designed to (1) prevent, reduce, and/or treat adolescent behavior problems, such as drug use, conduct problems, delinquency, sexually risky behavior, aggressive/violent behavior, and association with antisocial peers; (2) improve prosocial behaviors, such as school attendance and performance; and (3) improve family functioning, including effective parental leadership and management, positive parenting, and parental involvement with the child and his or her peers and school. BSFT is typically delivered in 12 to 16 family sessions but may be delivered in as few as 8 or as many as 24 sessions, depending on the severity of the communication and management problems within the family. Sessions are conducted at locations that are convenient to the family, including the family's home in some cases. Hispanic families have been the principal recipients of BSFT, but African American families have also participated in the intervention.

BSFT considers adolescent symptomatology to be rooted in maladaptive family interactions, inappropriate family alliances, overly rigid or permeable family boundaries, and parents' tendency to believe that a single individual (usually the adolescent) is responsible for the family's troubles. BSFT operates according to the assumption that transforming how the family functions will help improve the teen's presenting problem. BSFT's therapeutic techniques fall into three categories: joining, diagnosing, and restructuring. The therapist initially "joins" the family by encouraging family members to behave in their normal fashion. The therapist then diagnoses repetitive patterns of family interaction. Restructuring refers to the change-producing strategies that the therapist uses to promote new, more adaptive patterns of interaction. For more information, see the BSFT Web site (http://www.bsft.org).

COUNSELOR: Troy, I just want to be sure your rent situation is taken care of for now. Where do we stand with that?

TROY: Well, I think it's okay. I have emergency assistance that has paid what I owed for the past 2 months, and I'm current now. Section 8 housing has reduced my rent because I'm unemployed, but, you know, this #*%! public assistance doesn't really pay for crap. I got these two kids I gotta keep going. I'm not a rich man! I'm just not making ends meet.

COUNSELOR: Do you think you're ready to look for a job? You think you can handle that right now?

TROY: I don't know if I want to go back to work right away, because then I got a problem on the other end; we sometimes work until 6 at night. What are the kids gonna do for 3 hours?

COUNSELOR: Okay, let's work on child care if you need that. We need to make a plan that'll help you in the long run, so when you work and can't get home on time, the boys will still be cared for.

TROY: Does that mean they're gonna take the kids away from me?

COUNSELOR: No. This is all about helping you. We have a temporary childcare program here that will help you for up to about 2 months. That's the longest they will help you. It allows us to develop a plan for you. One option is for your mom to keep the boys in the afternoon. We did talk about your mom; you were concerned about the money you owed her.

TROY: [*worried*] Yeah. We're not talking much.

COUNSELOR: Tell me about when you were being raised up. Did you ever do anything that may have upset your mother? Like miss school, and she caught you, and she was upset about it?

TROY: Yeah. Well, we had our days.

COUNSELOR: And after those days happened, was your mom still talking to you?

TROY: Yeah. Yeah. I mean she's—yeah, she's all right.

COUNSELOR: So she continued to talk to you?

TROY: [*sounds anxious*] Yeah, but like, you know, I'm trying to do the best that I can. I gotta show her that I'm doing my thing, but I owe her all this money.

COUNSELOR: Do you think she would be proud of your being able to take care of a lot of the things you have taken care of, like your housing?

TROY: Yeah. Yeah. I see where you're going with this. I still feel kinda uncomfortable. You know, I don't feel so good about this, but maybe, maybe…

COUNSELOR: Okay. Let me ask you this. Let's practice for a few minutes what you might say to your mom and how she might respond. Then, what if you called your mom from here at the office to see if you can make some headway in how y'all get along. Do you remember how we did role-play when you were here in treatment?

TROY: Sure, I'd go with that.

COUNSELOR: Okay, let's start with you being your mom, and I'll be you. And talk to me, as if I'm Troy, about how you feel about me and how things have been going. I want you to really listen to your mom, see what she says. You may be surprised; she may be supportive, strong, and not worried much about the money. And I want you to hear what her concerns are about how you are doing and what she expects of you.

> **Master Clinician Note:** Role-play is an excellent counseling resource for helping clients prepare for difficult interpersonal situations. A description of how to set up a role-play and how it can be used is presented in the next vignette (René).

[Troy and the counselor proceed to role-play an interaction between Troy and his mom. Afterward, Troy believes that he understands more of where she is coming from and can more comfortably talk with her about the money he owes her and about her helping with child care.]

COUNSELOR: Let me change the subject for a minute and ask you how you are doing with not drinking or smoking weed.

TROY: Well, I had one beer the other evening, standing around outside with some other guys, and then I got to feeling bad about it. I had 9 days put together. But I know from here and AA that a beer is a beer. But that is all I've had, and no dope now for almost 2 weeks.

COUNSELOR: What about AA?

TROY: I've been twice, both to noon meetings because I didn't have anyone to watch the kids. I didn't see my old sponsor either time. I guess when I run into him, we'll have to get straight with each other.

[The counselor and Troy continue to talk for a few minutes about the need to remain clean and sober. They discuss the people, places, and things that might provoke a return to use. The counselor is supportive of Troy in finding alternatives to drinking or smoking marijuana.]

COUNSELOR: Okay. I appreciate all the hard work you've put into this. I think you've done a lot. I think you've made some positive changes. Do you agree with that?

TROY: So far, so good.

COUNSELOR: Okay, so what if we continue to meet once a week? If and when you get your roofing job back or another job, we'll look at how we can arrange counseling around your schedule. I remember that Carl often lets people take off an hour or two around lunch if they are going to a counseling session. And I think we have goals and priorities pretty set now: staying clean, keeping your housing, helping the boys get settled, handling stress and life problems, managing your finances, and getting back in good graces with your mom. Does that pretty well handle it?

TROY: Well, I'm better off than I was a month ago, that's for sure.

Summary

Troy experienced a number of significant stressors that were aggravated by marijuana and alcohol abuse and his difficulties in coping with stress. On presentation, Troy was in the action stage of change for keeping his housing and his kids and the contemplation stage of change for drinking and marijuana use. The counselor used a variety of techniques and multidisciplinary tools (for instance, consultation with the staff psychiatrist, referral to AA, supportive problem-solving, cognitive structuring, and role-play) to help Troy move ahead in the stages of change for addressing his marijuana and alcohol use and other life difficulties. Future sessions will focus on child care, improving parenting skills, preventing relapse, and maintaining his job. Long-term goals include helping Troy:

- Maintain stable housing through the Section 8 voucher program.
- Reduce his negative thinking and increase his hope and planning for the future.
- Maintain contact with his family for help with child care and recovery activities.
- Identify funds that he can use to pay his mother for helping with the kids.
- Identify after-school programs so his children can stay at school while he's working.
- Support stable continuation of recovery using agency resources and self-help programs.
- Continue to develop effective coping and parenting skills, problem-solving abilities, and stress management techniques.

Vignette 5—René

Overview

René is in the transition planning/ongoing homelessness rehabilitation phase. This vignette demonstrates approaches and techniques for substance abuse relapse prevention.

René is a 44-year-old man in intensive outpatient (IOP) treatment for heroin dependence. He relapsed once during treatment but recovered and got back on track quickly. His treatment program ends in 3 weeks, and he needs a new place to live—his current apartment is attached to the program. The stress of the impending transition contributed to his relapse. René used heroin after his last paycheck, but he did keep his job. He has a history of intermittent homelessness. His job doesn't pay well but offers benefits. He's a good fit for a sober living facility, which offers quality housing and social and abstinence supports.

Setting

Working in a substance abuse treatment organization's intensive outpatient program, the counselor offers case management and counseling services for transition into ongoing homelessness rehabilitation services and independent housing.

Learning Objectives

- Use counseling methods that support positive behaviors as objectively defined goals consistent with recovery and stable housing.
- Help client identify and change behaviors that are not conducive to meeting objectively defined recovery goals.
- Teach the client relapse prevention and life skills.

Strategies and Techniques

- Conceptualizing behavioral change activities oriented toward substance abuse recovery as therapeutic goal management
- Coping skills training conceptualized as short-term goals agreed to with clients to accomplish longer-term sustained behavior change

Counselor Skills and Attitudes

- Recognize and address underlying problem behaviors that may impede the client's recovery and housing stability.
- Facilitate the client's identification, selection, and practice of strategies, especially goal attainment, to sustain the knowledge, skills, and attitudes needed for maintaining recovery and housing.
- Recognize the importance of continued support, encouragement, and use of reinforcement and contingency management.

Vignette

Visit 1 (counselor's office)

The counselor has worked with René throughout his time in the IOP program. He's abstinent but nervous about the future. The counselor begins the first session with these goals in mind:

- Conceptualize René's recent relapse.
- Encourage him to increase his attendance at Narcotics Anonymous (NA) meetings.
- Discuss his housing options.

The counselor greets René and asks how he's been. René is in a tough spot, having relapsed while preparing to transition out of the program. If he didn't trust the counselor, he might respond with "I'm okay, I can deal with it," but they have good rapport. René believes she'll help him, so he offers an opening for help.

RENÉ: Man, life has been crazy. Working on that bull#*%! job, it ain't payin' nothing. I really don't have no clue what I wanna do in about 3 more weeks. My girl, she's trippin'.

COUNSELOR: It's a lot. I mentioned a halfway house and a sober living facility as steps toward building some quality sober time. What do you think?

RENÉ: I don't know about that #*%!. I want my *own* spot, you know?

COUNSELOR: I understand that you'd like your own apartment, and I hope we can work toward that.

RENÉ: #*%!, it don't make no difference! I don't make enough money. I don't know what I'm gonna do.

COUNSELOR: Well, would you be able to accept the goal of moving to a halfway house, and then, when you have another 60 days under your belt, we can talk about moving into a sober living house? We could talk about how you'd deal with that time in the halfway house.

> **Master Clinician Note:** The counselor should be aware of local housing options, including single room occupancy housing, shelters, halfway and transitional living houses, sober houses, Housing First, and other community housing opportunities. Each meets a specific housing need, and all have unique requirements for participation. Some have no financial requirements; some, such as sober housing, involve a fixed monthly rent based on ability to pay; and some require an agreement to pay a percentage of earned income. Some have no requirements about drug use or maintaining sobriety, but others require abstinence from alcohol and any illegal or illicit drugs. Some are for relatively short periods of time and others are ongoing. Each meets a unique need in the community.

RENÉ: I don't want that #!*%!. I had lots of time in that kind of by-the-rulebook living. I guess it's my fault, but I ain't making no money on that job.

COUNSELOR: You're thinking it's your fault? This situation?

RENÉ: Yeah, 'cause I been shooting dope for a long time. This #*%! may not even work for me. I probably waited too long, you know?

COUNSELOR: Well, René, I really hope you will work toward getting your own place.

RENÉ: Aw man, that #*%! is crazy. I'm tired of living with other people. You *know* how them places are?

COUNSELOR: You've done really well here. Except for that relapse, you've managed to use the program to your advantage. Can you allow yourself to feel good about that?

How To Help a Client Identify Triggers for Relapse

Working on relapse prevention is a good way to help many clients maintain housing. Identifying triggers is one way to start, and this can be done in several ways. Be respectful and kind; this conversation tends to evoke shame in clients:

1. Open with, "Tell me about what happened the last time you relapsed." The point is not to get a list of the triggers your client already knows about, but rather to really understand what happened this time.
2. Ask the client to look back in time to identify each choice point that led to the relapse.
3. Keep going back until you reach the point where the client veered from the recovery pathway into relapse. The choice point may be earlier than the client thought, or it may be a feeling he or she is reluctant to talk about. If it's a feeling, identify the thought that led to the feeling.
4. Help the client brainstorm and practice ways to handle the situation or feeling the next time. Role-play helps clients practice coping skills and develop a sense of mastery. It also increases self-esteem and provides further motivation to continue the recovery process.

For more information on identifying and addressing triggers, see the planned TIP, *Recovery in Behavioral Health Services* (SAMHSA, planned e).

RENÉ: Yeah! I'd never been clean very long before, so I'm real happy about that. But I think maybe this is the best it's gonna get for me.

COUNSELOR: If this is the best it's gonna get for now, let's talk about how you'll handle it.

RENÉ: #*%!. I don't know how.

COUNSELOR: Well let's talk about that relapse you had. What happened? I'm sure you've reviewed this in your treatment groups. We talked about this before, but let's just go over it again.

RENÉ: It was kind of a blur. I got off work and those dudes wanted to go out. They act stupid every time they drink, so I didn't wanna go with them. I was walking back to my place thinking about all this stuff that's going on, and I seen Cheryl and we started kickin' it. Next thing I know, I'm shooting dope.

COUNSELOR: So you got paid, you saw your girlfriend, and sort of went off.

RENÉ: Yeah. Now that I think about it, I can't remember many times that I've had sex without using. Maybe I don't think I can perform without dope. I don't know how, but that #*%! comes together for some reason.

Master Clinician Note: René has had this trigger for a long time. It's important to address it because it's a powerful trigger for relapse. The counselor can reflect what he's struggling with, ask about how he can be helpful, and go back farther to identify relapse triggers that happened earlier than this one.

COUNSELOR: So the main feeling that you're working toward is that feeling you have when you're high and having sex? So it's hard to imagine life without that?

RENÉ: Yeah. I guess so. That could be it.

COUNSELOR: Have you had sex with your girlfriend without being high?

RENÉ: Yeah, a couple times.

COUNSELOR: And how was it?

RENÉ: We really couldn't do the #*%! that I'm accustomed to doing, you know?

COUNSELOR: Um-hum. Was she high?

RENÉ: Yeah.

COUNSELOR: She was high and you weren't.

RENÉ: I wasn't. You can't really enjoy yourself or have the fun you wanna have, so you need something else to help you really enjoy it. Then you add on top of that the #*%! I'm going through. It could be one of a thousand things. It could be that I'm about to be homeless. Maybe that's it, and I don't wanna do that #*%! no more. I know when I'm loaded I can hustle and get some money and take care of my business.

COUNSELOR: So it's pretty hard to find a substitute for that, and yet you have just said the fear of being homeless again almost is enough for you to imagine you can give it up.

RENÉ: Yeah, the thought of that alone makes my stomach hurt. Have me where I can't breathe. You're asking me to see 6 months down the road. That's too long. Everything I do, I need immediate results, *immediate*. I go steal something, immediately I sell it. So waiting 2 weeks for my check, I'm struggling with that, because for years, I didn't have to delay nothing. And relationships—the first thing that I'm gonna do is get in a relationship, but in treatment and self-help groups, they tell you not to.

COUNSELOR: So, René, is it fair to say the first thing you want to do is enjoy yourself?

RENÉ: Yes.

COUNSELOR: The first thing you want to do is have fun, and right now, it's the old ways of having fun that you're thinking about. You're not aware of the new ways.

RENÉ: I don't know any new ways of how to really enjoy myself.

How To Help Clients Appreciate the Progress They Have Made

You can help clients like René, who are mired in feeling one step away from homelessness, see how far they have come (general strategies applicable to all clients are followed by specific examples taken from René's case):

- Elicit information about the changes they've made in their lives (e.g., by asking René, "What makes this temporary move different from all the other moves you've made in the past 20 years?").
- Shift focus (e.g., by saying to René, "Let's think of some things you could do that wouldn't lead to meeting Cheryl and getting high.")
- Reinforce recognition of triggers and insights (e.g., that René is scared about becoming homeless and having so much going on); unlocking triggers will help clients along the road to recovery.

The goal is to boost clients' self-confidence, which will continue to rise as they put together additional successes.

COUNSELOR: I understand it has been a long time since you enjoyed much of anything without being high. I'm wondering if there is anything you have enjoyed here in the treatment program—the groups, visiting with other people, helping someone out, something like that.

RENÉ: Man, that ain't FUN. That's just hanging out.

COUNSELOR: So it seems like things have to be high energy, high excitement to really be fun.

RENÉ: Maybe so. Otherwise it just seems boring. Like living in a damned halfway house or something.

COUNSELOR: Could we look for a minute at what would be fun that isn't bad for you in the long run?

RENÉ: Man, I don't know.

COUNSELOR: Well, it seems like we've raised several issues to work on here over the long haul. The first is how to have fun without it having to be high energy or high risk. The second is how to have some high-energy fun sometimes without getting into stuff that is destructive for you, like getting involved with drugs or maybe with Cheryl. The third may be to recognize when you are having fun and enjoying something that's just an everyday thing.

RENÉ: Man, that's high-level #*%!. I'm not sure I'm ready for that stuff.

[The counselor is satisfied to have raised the issue of how René conceptualizes having fun for right now. René has given a clear message that he is ready to change the topic. The counselor respects René's wishes and moves on to another topic raised by René earlier.]

COUNSELOR: Well, you said that the worst possible thing is to become homeless again.

RENÉ: Yeah, I know once I become homeless, I'd probably be going crazy. I lose my place, I go back on the street, I shoot dope and end up back in prison. And the nights are very scary.

COUNSELOR: You have been in this program for several months, and you haven't relapsed.

> **Master Clinician Note:** This is an example of strengths-based counseling: the counselor affirms René's strengths, eliciting that one of his strengths is the ability to derive support from his counselor and people in recovery. This, in turn, supports René's adaptive coping mechanisms.

RENÉ: Well, I don't wanna go back to prison. And then I was able to talk to you and the people in treatment. I have them for support, so…

COUNSELOR: So that is one way you helped yourself out of homelessness. [*René is looking away.*] I feel like I'm losing you because you're looking away. Can you look me in the eye?

RENÉ: Yeah, that's kinda hard.

COUNSELOR: Why is that kind of hard?

RENÉ: Uh…

COUNSELOR: Is it hard because I'm female and we're talking about intimate things?

RENÉ: [*tearful*] Well, I don't feel good about it, you know. I'm supposed to be way past this, but it seems like I'm just spinnin' my wheels. I'm not getting anywhere.

> **Master Clinician Note:** The shame that René is feeling can be challenging to a counselor. In this case, the counselor stays with it long enough to let René feel it. Then she reframes it as progress and helps him look forward to what he wants to do. As with all interventions, it is important that this intervention be handled in a culturally appropriate manner.

COUNSELOR: I'm hearing that you've come a long way and that you've had an idea now about what are probably some of your most difficult triggers, but you've got your finger on it.

RENÉ: Well, what's that?

COUNSELOR: We're talking about Cheryl and payday and when she calls. And also about fearing homelessness and getting fearful and then wanting to go out and use. I think you understand that it's what you have to do to get to where you want to be. You think to yourself, "I didn't like relapsing. I don't want to be homeless again." And yet here's this temptation in the form of your girlfriend. So what else can you do on payday when she's calling?

RENÉ: I need to quit that. That's for #*%! sure. If I wanna get myself in my own apartment, I'm gonna have to struggle with that, to not hang out with her.

COUNSELOR: So, how are you going to tell her? Or are you going to tell her that?

[They discuss whether and how René will be able to make a break with Cheryl.]

COUNSELOR: Well, how about trying that. Just not call her and not see her. Do you think that'll work? Can you give it a try and we'll see how it goes?

RENÉ: Yeah, maybe. I'll give it a try.

COUNSELOR: Now, what about these friends? The guys out on the street that hang out and want you to join them. We've talked a lot about that all through the program. It's real hard to hang out on the corner with all those guys who are high and not use.

RENÉ: Really, my friends are all in prison, so, it's hard for me to make friends. I probably need to try and meet some other friends. I really don't like the guys at NA. They're like, "You can't do this, you can't do that." I wanna be able to do everything anybody else does.

COUNSELOR: Well, if you're going to stay clean, you're going to need a good support system. You're talking about doing something that's difficult. It's payday, and you're trying not to have any contact with your girlfriend. There are people hanging around saying they want to be your friend because you've got a paycheck.

RENÉ: Yeah.

COUNSELOR: So, what other people are there—people to hang with and have a good time with who won't point you in the wrong direction?

RENÉ: You know, I really don't have any fun with nobody but people that are active users.

COUNSELOR: Are you going to meetings?

RENÉ: Yeah, I go to meetings.

COUNSELOR: How often do you go?

RENÉ: About 3 times a week.

COUNSELOR: What would you think of increasing that?

RENÉ: Honestly? Yeah, I know I need to go more. My sponsor tells me I need to go more.

COUNSELOR: How often does your sponsor say you need to go?

RENÉ: If you asked him, he'd say 7 days a week.

COUNSELOR: That sounds like it might be a good idea.

RENÉ: That's way too much. It's bad enough sittin' in those meetings. But, that could be an option. It's only an hour. So, how about this halfway house you were talking about?

COUNSELOR: Well, it's warm, it's got beds, meals, a bunch of guys who aren't using on site. It's not treatment, everybody takes part in taking care of the house, and if you're interested, they can help with things like getting a better job. It's not treatment, but it's a safe place for another 30 or 60 days; after that, we can maybe get you into a sober living house.

RENÉ: How long would I have to stay there in sober living before I get my own place?

COUNSELOR: Well, it is going to be a while, probably at least a year or two, before you have a steady income and are back on your feet. You want to go by and check it out?

RENÉ: I guess we can go by and take a look at it.

COUNSELOR: I think the other thing we'll do is to plan to meet pretty often between now and your discharge time a couple weeks from now.

RENÉ: Yeah, that would be good, because I have more of a relationship with you than I have with anybody else. I feel comfortable talking to you about these kinds of things.

COUNSELOR: When is payday?

RENÉ: Uh, next week.

COUNSELOR: So, let's start with that day. What do you want to happen?

RENÉ: I really don't know.

COUNSELOR: What did you say before? Let's talk about how it can be different from other paydays.

[René and the counselor create a plan for payday, which includes avoiding Cheryl, buying something with his money so he won't be tempted to use it to buy drugs, and going to the movies and

getting something to eat as a fun, substance-free recreational activity. René agrees to consider staying at a halfway house after he leaves the IOP housing, to attend sessions three times a week, and to continue to give urine screens.]

Visit 2 (counselor's office)

René had an insight about why he has been stuck and risking relapse, and he seems ready to try out some ways to avoid further relapses. The counselor has the following goals:

- Review how René handled the weekend.
- Assess his current ability to effectively manage high-risk situations like running into his ex-girlfriend.
- Practice refusal skills and other appropriate skills as needed.

The counselor asks René about payday; he says he didn't see Cheryl. He bought a cell phone, got some food to eat, and saw a movie. The counselor reinforces this achievement and asks René to tell her about it.

RENÉ: Well, it was a lot of work, because I was thinking about it the entire night before. I was thinking about what I was gonna do when I get my check and how I was gonna do it, so it wasn't easy. How not to go see Cheryl, what if I do see her? The more I tried not to think about seein' her, the more I thought about seein' her. So, it was good we talked about it in advance, because it was a struggle not goin' into the store to cash my paycheck. But, I went to the cell phone store instead. I kept telling myself, "Hey, look, I'm goin' to get me a cell phone, you know, and that's what I'm gonna do."

COUNSELOR: Did you have the thoughts of being homeless, being back in jail?

RENÉ: No, because if I have thoughts about that, I'd have to see Cheryl.

> **Master Clinician Note:** The counselor notes the connection between Cheryl as a relapse trigger leading to René's being homeless. She decides not to present this to René right now because it would lead their discussion in a different direction. The counselor wants to stay focused on managing high-risk situations, building refusal skills, and building other strengths.

COUNSELOR: Okay, so, the fact that you got through that day is very commendable. And now it's about having more clean time, building that into the future.

RENÉ: Yeah, it kinda put it into perspective—one day at a time.

COUNSELOR: I think we do need to deal with the fact that your ex is going to try to find you.

RENÉ: Yeah, I'm sure she is. Matter of fact, I know she is.

COUNSELOR: So, in a couple more days, you're getting another paycheck, and this time she's going to say, "I'm not letting that guy avoid me this week!" So I thought maybe we should play it out a little bit. So, can you put yourself in her shoes and pretend you're her?

Master Clinician Note: In this situation, role-play can help René experience the immediacy of feelings he will face when he sees his ex and rehearse a plan to manage these feelings while interacting with her. The counselor and René will role-play twice. The first time, the counselor will play René and model behavior. The second time, René will be himself in the role-play. René is already familiar with role-plays because they use them in the treatment program. When introducing role-playing for the first time, you should expect that the client may feel silly or uncomfortable. Reinforce communication of this discomfort and provide an explanation for the purpose of the role-play. For more information about conducting a role-play, refer to the planned TIP, *Recovery in Behavioral Health Services* (SAMHSA, planned e).

RENÉ: Yeah, because she's been bullyin' me for a while.

COUNSELOR: Okay, so we're going to take ourselves to the store. Okay, the usual thing that happens is you have the check, you go to the store.

RENÉ: Cash my check. Get me an iced tea and a couple of scratchers.

COUNSELOR: Okay, and there she comes. She pops in. So, I'm going to be you and you're going to be Cheryl. Okay?

RENÉ: Okay.

COUNSELOR: So here I am as you, I've got my check and I buy my tea and scratchers, and I'm heading out to figure how to use that cell phone better and think about a movie, and there you come. Go ahead.

RENÉ/CHERYL: Hey, René, what 'cha doin'?

COUNSELOR/RENÉ: Hey, Cheryl, just, uh, mindin' my own business. Just gonna go hang out.

RENÉ/CHERYL: Win any money on that scratcher?

COUNSELOR/RENÉ: No, not this time.

RENÉ/CHERYL: Well, you gotta be in it to win it. You win a million dollars, what 'cha gonna do?

COUNSELOR/RENÉ: Get as far away from here as I can.

RENÉ/CHERYL: Gonna take me with you?

COUNSELOR/RENÉ: Cheryl, I gotta live my life without you. I can't have you in my life. I know that you didn't see me last weekend and you probably thought, "Well, he forgot about me this week," but you can't go with me any longer.

RENÉ/CHERYL: Quit playing, René. #*%!, you know you love me.

COUNSELOR/RENÉ: I can't do it, Cheryl.

RENÉ/CHERYL: You *know* you like me!

COUNSELOR/RENÉ: Can't do it, Cheryl.

RENÉ/CHERYL: Ain't *nobody* gonna treat you the way *I* treat you.

COUNSELOR/RENÉ: I like the way you treat me, Cheryl, but I can't go back down that road. Seeing you, I see drugs, I see love, I see sex, I see disappearing into some bedroom with you. I'm never getting back from there, or goin' in there with you again.

RENÉ/CHERYL: Well, what do you want me to do? Maybe I don't want to live my life without you. Did you think of that?

COUNSELOR/RENÉ: I gotta take care of myself. I don't know whether I can tell you what you can do for yourself, but I know for myself that you gotta get out of my life, and I gotta get you out of my life.

RENÉ/CHERYL: [*forlorn*] Look, I feel lonely, baby.

COUNSELOR/RENÉ: I'm going. I'm gonna go back to that telephone store, I'm gonna learn how to work this thing, I'm gonna pick out a—

RENÉ/CHERYL: Oh! so you think you're too good for me now! *You* go to a treatment program, *you* get on this high-ass horse; *you* get a few dollars for bus fare, and now *you* too good for me!

COUNSELOR/RENÉ: No, I don't think I'm too good for you. I just can't be this close to you anymore.

RENÉ/CHERYL: You talk that #*%! about you care about me, and all that!

COUNSELOR/RENÉ: I'm done. I'm gone.

> **Master Clinician Note:** The counselor models imperfect responses and struggles a bit so the client doesn't end up thinking "I could never do that!"

[The first role-play ends, and the counselor and René return to being themselves.]

COUNSELOR: Okay, René, how did you think that went, that little exercise that we just did?

RENÉ: I see she really don't care about me. She's just an addict. When she said "you think you're better than me," I believe that I'm better than the dope game. I work hard not to be a dope fiend, so, yeah, I'm better than her.

COUNSELOR: Okay, well, you gave me a hard time during that. It was tough to walk away.

RENÉ: Cheryl would probably create a scene in that store, and I probably would have had to leave—that's the only way you can deal with it.

COUNSELOR: Okay, how about we reverse it now, and I'll be Cheryl, and you be yourself.

RENÉ: All right.

COUNSELOR: So, you're coming out of the store, and here I come.

COUNSELOR/CHERYL: Well, hey there, René, where ya been?

RENÉ: Hey, what's up, Cheryl, how ya doin'? I don't have time, girl, I'm on my way. I gotta go.

COUNSELOR/CHERYL: Hey, you know, you dissed me last week. I didn't like that very much.

RENÉ: I ain't never dissed you.

COUNSELOR/CHERYL: Did you miss me?

RENÉ: No.

COUNSELOR/CHERYL: Aw, come on now!

RENÉ: Cheryl, you don't give a #*%! about me; all you interested in is dope and I—

COUNSELOR/CHERYL: [*cooing*] You know I love you, you know I love you.

RENÉ: Would you love me if I was broke?

COUNSELOR/CHERYL: Sure, I'd love you if you were broke. But, you know what? I got paid today. I got us a room! Come on, come on, René. Let's go.

RENÉ: No, no. I'm not cool with that.

COUNSELOR/CHERYL: Come on, I got some for us to share, baby.

RENÉ: No, no. I'm not cool with that.

COUNSELOR/CHERYL: I got some *really* good #*%! here, René.

How To Follow Up Role-Play

In an individual session

1. Keep having the client do brief (2 minutes or less) role-plays to build confidence that he or she can do it.
2. If the client shows inability to follow through (e.g., the client gives in), one appropriate response would be, "Well, that didn't go so well, what do you need to do the next time to walk away?"

In a group session

When using role-play in a group, the clients are often much tougher than the counselor. When the client is successful in coping under these conditions, he or she has gone through both an emotional and a behavioral experience. Following the role-play:

1. Ask the person playing the client what he or she did well first; then ask, "How could you do it better?"
2. Ask the clients in the group what they thought went well and what could have been done better without repeating what someone else has observed.
3. Summarize the most important feedback: "Here's what the group said you could've done; let's do it again."
4. Repeat brief role-plays (about 2 minutes) until the client has a sense of mastery, and he or she is demonstrating an ability to handle the situation well.

Very short, repetitive role-plays work best. Each time clients role-play, they learn something more. When they feel they've learned all they can, their sense of mastery has improved and they feel they are prepared to handle the situation. If clients experience craving at the end of the role-play, use this as an opportunity to teach them to manage cravings.

RENÉ: I can't do that.

COUNSELOR/CHERYL: Come on, come on! Let's go, René.

RENÉ: No. I'm not cool with that. No. I've had it. I'm outta here! [*René gets up and walks away.*]

COUNSELOR/CHERYL: Come on, come on, René! You know we can feel good.

[René agrees to go to NA more often and has practiced coping skills in case he sees Cheryl. In the next session, it will be important to follow up on his use of these skills, explore how René manages his next encounter with Cheryl, and do more role-playing (if needed) to address any challenges that arise. He is ready to move into the boarding house and doesn't feel as vulnerable to relapse.]

Visit 3 (counselor's office)

René has decided he will stay in the halfway house until he is eligible to enter a sober living housing unit. He completed the outpatient program last week and had to vacate his program-provided apartment. The counselor begins Visit 3 with the following goals in mind:

- Review his attendance and commitment to daily NA meetings.
- Review relapse prevention coping skills.
- Review skills he needs to practice for long-term recovery.

The session begins with a review of how René is adjusting to the halfway house.

COUNSELOR: All right, well, the past couple times we met, we've been talking about how things have gone on payday, and we did the role-play about what you'd do if you ran into Cheryl.

RENÉ: Yeah, I really liked that. I saw her at a distance right before she saw me, so I got away.

COUNSELOR: There you go.

RENÉ: Yeah, I know, even though we went through that, you know, and I role-played, I really just want to keep myself from being in that position, so if I can see her first, I won't come in contact with her.

COUNSELOR: So, that'd bring up all kinds of feelings again.

RENÉ: Yeah, not that I don't know if I could deal with them or not, that's not the real issue. If I can keep from dealing with Cheryl in any form, I'm okay. But I know I'm eventually gonna run into her.

COUNSELOR: So, you've been going to your meetings?

RENÉ: Yeah. That sponsor of mine, he's crazy. He wants me to make a commitment, you know. I'm already working and #*%!, I can't do that. He wants me to be the coffee person at the meeting, you know, go buy the stuff, go do my 4th step, make the commitment.

COUNSELOR: So, what's your reluctance about making the commitment?

RENÉ: I don't have time. I don't wanna be the coffee person.

COUNSELOR: Okay. Well, at this time, you're going to need as many places as possible to be that are good places for you to be.

RENÉ: Yeah, that's what he said, too. Safety. Responsibility.

COUNSELOR: So, if it isn't being a coffee person, what else can you build in right now? What else are you doing besides the meetings and work and spending payday avoiding your girlfriend? How is halfway house living coming?

RENÉ: Well, it's okay. Some of the people I knew in the program are there. I like playin' chess, so I might start playin' chess again. There is one guy in the house who says he will play with me. I really do have time to be the coffee person, you know. I guess that's my own thing, not wanting the responsibility.

COUNSELOR: Sounds like maybe you want to do it. Maybe you're just talking yourself out of it.

RENÉ: Yeah.

COUNSELOR: It can be hard to make a commitment to another person.

RENÉ: Yeah, this guy wants me to do it. When I say, "Why do I have to be the coffee person?" he says, "Just be the coffee person." He needs to tell me what I'm gonna get out of it. I don't wanna just do it because he wants me to.

COUNSELOR: Well, you're always on time for appointments. You can keep an appointment. I'm wondering what it would do to how you think about yourself if you were responsible and dependable.

RENÉ: Well, I just don't think of myself that way. That ain't me.

Master Clinician Note: The counselor is helping René clarify how recovery-oriented relationships that include commitment and responsibility can be adaptive, healthy, and rewarding in contrast to his maladaptive relationship with Cheryl, his lack of responsibility in the past, and his reluctance to commit to anything.

RENÉ: I may be getting to the point where I don't need to go to meetings that often, you know?

COUNSELOR: So maybe you're trying to get away from committing yourself to the meetings.

RENÉ: Well, #*%!, I don't need to go 7 days a week.

COUNSELOR: Remember now, René, we're working on finishing your 60 days in the halfway house, then looking forward to moving into sober living. It's going to be here sooner than you know.

RENÉ: Yeah, yeah.

COUNSELOR: You're independent even in this, you know. And being in sober housing will be another step. In sober housing, there's nobody cooking, just a few other guys around, doing their thing, no staff. You'll be pretty independent.

Master Clinician Note: The counselor senses that René has begun a significant shift in his thinking about abstinence, relationships with others, personal attributes (e.g., responsibility, commitment), and his own personal sense of worth and dignity. He has found hope that he can reach for and achieve a quality life. These shifts accrue as a result of abstinence, stable living (such as stable housing and new "clean" friends), and quality treatment in the program. René still needs to incorporate these changes on a consistent basis but is making significant efforts in all these spheres. The counselor wants to support René's new view of himself in relation to the world and will continue to reinforce this growth in subsequent visits.

RENÉ: Yeah, but, I'm thinkin' he wants me to take the coffee commitment 'cause he thinks I'm gonna use if I don't take it. I'm saying I don't need to have a coffee commitment to keep me from using.

COUNSELOR: This is a big concern of yours right now. Someone else is relying on you.

RENÉ: Yeah, because now I can't miss. I know he thinks that it'll force me to have to go to the meetings. It gives me some responsibility, you know, so I'm gonna do it for a while. I can't say that I'm gonna be there for every meeting as coffee person, but I'm gonna try.

COUNSELOR: I think it's a good thing for you to do. You've been focused on yourself and your recovery, so now you're doing something for other people. It could be a good feeling, having people relying on you.

RENÉ: Well, maybe.

COUNSELOR: So, what else is going on?

RENÉ: Well, I need to make more money. The job—I need a new job. I'm gonna try to buy me a car, you know, and I wanna move into my own place.

COUNSELOR: Those are great goals, René. So, have you tried to get leads on something that might offer more pay?

RENÉ: That's the thing, you know. I don't know how to look for another job. The folks at the halfway house said they would help.

COUNSELOR: Well, how about if we go back to the halfway house director, maybe on your day off, and see what he might have? They have some stuff posted on the employment board.

RENÉ: Yeah, that's not a bad idea.

Master Clinician Note: The counselor is focusing on René's natural supports (NA meetings, his job, and maybe his family) to help him develop supports for his recovery.

COUNSELOR: Have you been in touch with your family at all?

RENÉ: Uh, no, not really. Been away from them a long time.

COUNSELOR: What do you think about making some contacts? Pretty soon, you'll have your own place. You can maybe have them over for coffee. Or are you thinking that would feel like too much pressure?

[They discuss reconnecting to René's family, particularly an uncle.]

COUNSELOR: Now, I'm just thinking about another person who might show their face while you're in sober living. Who do you think that might be?

RENÉ: Let's see, who could that be? [*laughs*] You're talking about Cheryl.

COUNSELOR: Yeah, I am. Have you thought about how that's going to work?

RENÉ: Well, first, she don't know where I'm staying. You know, I'd never give her my address. Haven't given her my phone number either. I don't go to that store anymore.

COUNSELOR: Have you been feeling lonely?

RENÉ: Yeah, you know, that's part of why my sponsor had me go to those meetings a lot. Doesn't give me a chance to be lonely. I'm still around a lot of people I can talk to.

COUNSELOR: You said you were not a real big people person, kind of a loner.

RENÉ: Yeah, but I'm in the room with them, so, it's all right. Yeah, I saw a girl there and we've been talking. She's in recovery, too, so it's all right.

COUNSELOR: Someone to think about for down the line.

RENÉ: Could be. Could be a prospect, yeah. But, you know, I really want to change jobs.

COUNSELOR: You changed the subject pretty quickly.

Master Clinician Note: The counselor understands René's abrupt shift to another topic as signaling his discomfort but decides to further explore the relational issue and help him begin to resolve it.

RENÉ: Yeah. I'm—

COUNSELOR: Maybe you need to think about how to deal with women who aren't using.

RENÉ: Well, my sponsor told me that I shouldn't be in a relationship anyway, you know?

COUNSELOR: This sponsor sounds like a very important person.

RENÉ: Yeah, well, he thinks he is. He has some good information—some good, some bad, some I don't agree with. But I have his number, and then if something happens, he tells me don't call him after I get high, you know. Call him before. Can't really do too much *after* I'm high.

COUNSELOR: So, it's been a while since you've been high. How's that going?

RENÉ: Going okay, you know? Got some good tools I use, you know. I do what they say; I play the tape all the way through, I see the consequences.

COUNSELOR: There's a lot going on. You moved, you're still adjusting, there's another move coming, you're staying clear of Cheryl, you're seeing other women, *and* you're keeping off drugs. That's a lot.

RENÉ: Yeah, it's tough!

COUNSELOR: You've stayed with the plan on payday, you haven't relapsed, you're making the best of being here, you're doing more meetings, and you're maybe thinking about making some contact with your family. That's all really good stuff.

RENÉ: Yeah, well, it's pretty good. I guess they say I'm well on my way, huh?

Master Clinician Note: The counselor continues to affirm René's strengths and what he has accomplished. This supports René's confidence in his ability to maintain his recovery and continue the evolution of his identity toward becoming a contributing member of his community and away from homelessness and substance abuse as a coping strategy.

Summary

René has come a long way. He slipped but worked with his counselor to stay in the action stage of change through the techniques used in transitioning from homelessness intensive care to ongoing rehabilitation (i.e., affirmation, identifying strengths and relapse triggers, role-playing, and increasing and generalizing coping skills). He moved from precontemplation to action for ending his relationship with his girlfriend and from contemplation to action about moving into a halfway house temporarily until he has enough time abstinent to enter a sober living home. He increased commitment to substance abuse recovery supports through involvement in NA.

Longer-term goals for working with René include:

- Ongoing engagement in mutual support groups and the recovery community.
- Reconnecting him with his family, including using role-play to practice asking his uncle to go fishing, having dinner with his aunt and uncle, and facing recriminations from his family.
- Finding a better job; using role-playing of job interviews until René has developed the skills he needs for telling the truth about his background.
- Assessing René's money management and living skills and improving them if necessary.

Vignette 6—Mikki

Overview

Mikki is in the early intervention stage of homelessness prevention. This vignette demonstrates approaches and techniques for preventing additional trauma to her family during temporary homelessness.

Mikki's partner of 4 years has abandoned the family, leaving Mikki with sole responsibility for their daughter, Emily, age 3, and for Madeline, age 7, Mikki's daughter from a previous relationship. For a couple of months, he sent some money, but for the past 2 months he has not been heard from. Mikki does not know where he is and does not expect him to return.

She presents in the local community health center with one child with a high fever and both children with bad colds and coughs. On interviewing Mikki, the nurse practitioner picks up on her significant depression and begins to question her about the family's living situation. She is concerned that Mikki's level of depression will not allow her to provide care for the children, particularly in emergency situations with their illnesses.

In the discussion, the nurse learns that Mikki has been evicted from their apartment and that the family has been living in her car (which is not working) for the past week. Mikki takes the older child, Madeline, to school each morning (except this morning, because Madeline is sick). She and the younger child, Emily, sit and play in the park all day. Mikki has no plans for coping with the crisis and, with her depression, can barely make it from day to day. She has been receiving some meals for her and the children at a local soup kitchen but has not told kitchen staff that she is homeless.

The practitioner is faced with three immediate problems:
1. Intervening with the children's health problems
2. Intervening with Mikki's serious depression
3. Helping the family find temporary emergency housing

The nurse contacts Bill, the behavioral health counselor/case manager at the community health center. The vignette depicts Bill's work with Mikki and the children.

Setting

Mikki and her two children present at a community health center. Bill, the caseworker, is called in after the nurse practitioner identifies the family as homeless and in need of acute care. Bill recognizes the complexity of this case, which, by his determination, calls for intensive case management and a team approach to care. He mobilizes resources within the health center and in the community to respond to the complex needs of this family.

Learning Objectives

- Recognize homelessness or incipient homelessness with individuals and families who present with other problems and do not identify homelessness as the presenting problem.
- Screen for and identify behavioral health problems and apply appropriate resources to address those problems.
- Mobilize and coordinate resources to provide interventions for complex, multiproblem families.
- Implement prevention strategies to limit the trauma of homelessness in families.

Strategies and Techniques

- Case management with families facing multiple problems
- Using SBIRT as a strategy for identifying substance abuse and substance use disorders
- Prevention strategies to engage children and parents in families experiencing homelessness
- Using a team approach in working with families with complex behavioral health issues

Counselor Skills and Attitudes

- Develop rapport with someone who is depressed and overwhelmed.

- Develop and implement a treatment/recovery plan for people in acute crisis who have co-occurring disorders.
- Develop case management skills in work with complex, multiproblem families.

Vignette

Visit 1 (health center)

The nurse practitioner has contacted Bill, a counselor who is currently seeing another client; Bill says he can see Mikki in about 45 minutes. It ends up being more than an hour before Bill is free, and Mikki becomes cranky. Emily, who waits with her mother, is restless and beginning to run up and down the hallway near the waiting room. Madeline is still in the pediatrician's office.

COUNSELOR: I'm sorry you have had to wait today. Things are pretty hectic around here this morning.

MIKKI: Will someone tell me when Madeline is through with her visit to the doctor?

COUNSELOR: Yeah, the nurse is going to call us. When she does, Madeline can join us here. I understand Madeline is feeling pretty bad today.

[Bill wants to initiate some connection with Mikki and involve her in a conversation but doesn't want to rush right into all of the overwhelming problems Mikki is facing. He engages Mikki in talking about the children's current health problems, and although Mikki continues to seem somewhat distant, she seems less cranky. Emily has put her head in her mother's lap and is beginning to doze off. As Bill senses Mikki feeling a little more comfortable, he asks a general question about her current situation.]

COUNSELOR: Mikki, it seems like you have a lot going on right now, some really tough stuff happening in your and your girls' lives.

MIKKI: I don't know how I'm going to handle all of this.

COUNSELOR: Well, we want to help you. Right now, Madeline is getting taken care of and Emily got a prescription from the doctor, so let's talk about your housing situation. I understand you don't have a place to live right now.

MIKKI: Not since last Tuesday.

Housing Options for Families in Crisis

In any particular community, a variety of housing options might be available for families in crisis. At the same time, no community is likely to have the full range of necessary housing services for families. Some organizations may have a complete range of "wrap-around" services available, such as assertive community treatment, emergency and comprehensive health services, family counseling, employment assistance, and a food pantry. Other organizations may simply provide housing. Some programs have restrictions on the length of time families may stay, whereas others provide permanent supportive housing. Some resources may be limited to mothers and their children, whereas others accept intact families. It is important for you and your program to be aware of the services available in your community, as well as to be aware of the gaps in available services.

COUNSELOR: Okay, Mikki. Let's take first things first. In addition to getting Madeline well, it seems most important right now that we help you get a place to stay for tonight that is safe and out of the weather.

[Bill proceeds to gather the information necessary from Mikki to arrange temporary housing. He also explains to Mikki that, for tonight (and maybe the next few days), he will arrange shelter housing; in the interim, they can plan for more stable housing. Bill also realizes that Mikki is depressed and overwhelmed. It might be a problem for her to go to the housing office for assessment on her own because her car is not working, but he has no immediate resources for taking her there. The office is about eight blocks from the health center. He therefore arranges for bus fare for Mikki and the girls.]

MIKKI: I don't have any money.

COUNSELOR: Mikki, I'm thinking if you can return here tomorrow, we'll start getting you some income support until you can get back on your feet and maybe start working.

MIKKI: That sounds okay.

[Madeline now enters the room accompanied by a nursing assistant from the pediatrics department. She is a shy, thin child who does not make any eye contact with Bill. When the nursing assistant leaves the office, Madeline sits quietly next to her mother. Emily begins to stir, but Mikki doesn't seem to respond to Emily's waking up.]

COUNSELOR: Well, Mikki, if the kids are ready, maybe you should head over to the shelter

Family Shelters and the Need for Permanent Housing

Shelter services provide emergency housing services to families without a place to live. Often, these services are limited to mothers and children who require immediate housing resources and are time limited in nature. A variety of dynamics drive families to shelters and other transitional housing resources: the lack of local low-cost housing, the disparity between housing costs and income, domestic violence, and limited availability of other social service resources, among others. Some of the barriers faced by families who are homeless are available cash for a rental damage deposit and first and last months' rent, limited housing stock for larger families, and the reluctance of landlords to rent to individuals who have been previously evicted from housing or who have a poor credit history. These dynamics create a cycle of emergency homelessness crises for families in need.

Shelters and other transitional housing meet a significant need in most communities. However, shelters are often just the first step needed by a family without housing. Most housing experts cite the need for intensive long-term housing assistance for families to stabilize and grow beyond the immediate crises that caused their homelessness in the first place. Supportive social services for employment, behavioral health services, physical health care, education, clothing, and food are required over a longer period of time than can be provided by most transitional services.

Housing First is an option for emergency shelter/transitional housing. As the name implies, this program sees adequate and sustained housing as a precursor to support families as they get back on their feet. In addition, Housing First services provide social services to support families. The four stages of most Housing First programs are: crisis intervention and short-term stabilization, screening and needs assessment, provision of housing services, and provision of case management services.

Source: National Alliance to End Homelessness, 2006.

offices to arrange for housing for tonight. Then tomorrow, be back over here at 9, and let's see what we can do to start working on things like income and more stable housing.

[Mikki bundles up the girls, takes the bus fare and a map to the shelter office, and leaves the health center with a return appointment for the next morning.]

After Mikki leaves, Bill spends a few minutes developing some ideas for addressing Mikki's needs. Some of the actions he identifies, in order of priority, are:

1. Find housing for the next couple of days, and, in the interim, arrange for more stable housing.
2. Arrange for the family to receive intensive case management and social work services from the health center that will allow Bill and other support personnel in the center to provide more concentrated and intensive services.
3. Address Mikki's depressive symptoms.
4. Find an income source that can support Mikki and her daughters until she can gain employment.
5. Monitor the needs of the children; in particular, monitor Madeline for school attendance and potential depression, ensure that the health and safety needs of both girls are met, and arrange interventions to mitigate any trauma they may experience due to their life situation.
6. Help Mikki access resources she needs to apply for a job that can help her support herself and her children.

Visit 2 (counselor's office)

Mikki returns to the health center the next morning at 9 to see Bill. She is accompanied by her 3-year-old, Emily. Madeline went to school this morning. Mikki looks disheveled, despondent, and overwhelmed and doesn't seem to be responding to Emily's efforts to stay close to her. After yesterday's visit, Bill requested and got approval for increased intensity of casework services. This allows Bill and a case aide to see Mikki on a more regular basis and to accompany her to appointments that are critical to the family's welfare.

Bill invites Mikki and Emily into his office.

COUNSELOR: I hope you got to the housing office okay yesterday. How's it going?

MIKKI: We got to the housing office yesterday after it closed, and the shelter wouldn't let us in without a voucher, so we slept in the car again last night.

COUNSELOR: Did you and the girls get any breakfast?

MIKKI: We had some supper at the open kitchen down the street from the housing office. I don't have any money for breakfast.

COUNSELOR: Okay, then as soon as we finish here, I'll arrange a food voucher for you and Emily to get something to eat. Would it be okay with you if I call Madeline's school and see if we can arrange for her to get breakfast and lunch there each day she attends?

[Mikki nods her assent to both statements, and Bill proceeds to complete a release of information form with her, which will allow him to communicate with the school counselor. Mikki signs the form without really reading it. Bill notices this and proceeds to explain what the form means.]

Effects of Homelessness on Children

Children in families that are homeless are affected at all psychodevelopmental levels, from before birth to late adolescence. These effects influence physical growth, emotional and behavioral development, academic performance, and interpersonal and social skills development (Shegos, 1999).

Additionally, homelessness for children, as well as for adults, rarely exists in isolation; rather, it occurs most often in the context of other dynamics such as the potential for violence, poverty, living with recurring crises, inadequate nutrition, and family breakup. As a result, children in families that are homeless are at particular risk for trauma and developmental and behavioral disorders. For more information on trauma-informed care for children and families who are homeless, see SAMHSA's National Center for Trauma-Informed Care Web site (http://www.samhsa.gov/nctic/) and SAMHSA's Homelessness Resource Center Web site (http://homeless.samhsa.gov/).

COUNSELOR: Mikki, I sense that you are pretty down in the dumps this morning.

MIKKI: Have you ever tried to live in a car with two daughters and one sleeping bag? I don't have any money. I'm tired. I don't know where we will sleep tonight. I haven't had a bath in 3 days.

[Mikki begins to tear up. Bill just sits silently for a few moments without interrupting her.]

COUNSELOR: I understand that things are really overwhelming for you right now. It must feel very difficult for you to get anything done. But I'm here to help you, and together, we can begin to take these big problems and deal with them one by one. Now first, I'm going to arrange for Kate, our case aide, to go with you this morning after you've had breakfast to enroll you and the girls in the family shelter housing program for a few days until we can get something better worked out. It's safe, and you'll have a place for your stuff, a bathroom, and a small breakfast meal to get you all going in the morning.

Once we have that squared away, Kate is going to walk over with you and Emily to the Department of Human Services to help you get enrolled in some emergency financial assistance. It won't be a lot of money, but it will help you get through the next few weeks. Are these plans okay with you?

MIKKI: Well, I don't have anything else to do, that's for sure. I do have to meet Madeline at the school at 3. She gets real nervous if she thinks I'm not going to be there.

COUNSELOR: No problem, we should be able to get the housing and income assistance stuff tucked away well before 3. Now, Mikki, there is one more thing I would like us to do this morning, and then we can arrange for you and Emily to get some breakfast—and that is, I would like you to see a doctor on our staff, Dr. Wright. I know you are really overwhelmed and pretty down right now, and that is really sapping your strength. We're taking care of the girls' health, but your health is important, too. So, I want you to see Dr. Wright, who is our staff psychiatrist. Let's see what we can do to help you get more energy, get some good sleep, and feel more hopeful about things.

[For more information about depressive symptoms and their treatment, see TIP 48, *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery* (CSAT, 2008).]

MIKKI: You want me to see a psychiatrist?

COUNSELOR: I'm concerned that you may be depressed, and, like any illness, depression is likely to get worse if it isn't treated. We have a lot of resources here at the health center that can help you, and Dr. Wright is one of them.

[Mikki reluctantly assents. Bill takes a moment in the presence of Mikki to call Dr. Wright's secretary and arrange for an assessment interview later in the week. He then writes down the appointment time for Mikki and arranges for her to come by his office for a few minutes before she is scheduled to see Dr. Wright. He then arranges for Mikki to receive two meal vouchers from the health clinic and schedules Mikki to meet Kate, the case aide, in 1 hour. While Mikki is having breakfast, he updates Kate on the case. Kate will be able to check in with Mikki regularly just to make sure everything is going all right. He then calls Madeline's school and speaks with the school counselor, who suggests that, in addition to enrolling Madeline in the breakfast and lunch programs, she can meet briefly with Mikki this afternoon when she comes to pick up Madeline and see what support she can offer Mikki and Madeline.

Bill prepares his case notes and a referral request to Dr. Wright, describing his concerns about Mikki's depressive symptoms and the efforts that have been taken to support Mikki and her daughters.]

Later in the week

Mikki, with Kate's help, got housing through the family shelter, arranged for Madeline to remain in the school meals program, got emergency financial assistance, and kept her appointments with Bill and Dr. Wright. Dr. Wright suspected that alcohol use might be contributing to Mikki's depression and conducted an SBIRT assessment.

The screening indicated that Mikki was using alcohol in a manner consistent with substance abuse, particularly in the past month. The brief intervention consisted of a discussion with Mikki about her alcohol use, helping her understand the ways in which alcohol might heighten her depression and interfere with her recovery. This elicited her cooperation in remaining abstinent

Screening, Brief Intervention, and Referral to Treatment

As described on SAMHSA's SBIRT Web page (http://www.samhsa.gov/prevention/sbirt), SBIRT is a comprehensive, integrated public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur:

- Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment.
- Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.

Please refer to the SBIRT Web page listed above as well as the text box on page 36 of this TIP for more information on SBIRT.

while in treatment for depression and her participation in continuing follow-up with Bill. She was encouraged to attend a weekly support group that meets at the family shelter. Bill will follow up with Mikki on her efforts toward abstinence and monitor her mood. She has a return appointment in a month to see Dr. Wright. Additionally, Dr. Wright prescribed an antidepressant medication for Mikki.

Visit 3 (one month later, counselor's office)

Kate, with Bill's support and supervision, has continued to check in on Mikki twice a week. Mikki's depressive symptoms are less intense, and she seems to be doing a better job of supporting her children. After spending four nights in the emergency family shelter, Mikki and the girls moved to transitional family housing, where they continue to live.

Bill has maintained contact with Annette, the counselor at Madeline's school, who has helped Bill understand some of the effects of homelessness on young children and some of the programs and resources that are available for children to prevent additional, compounding problems. Through Kate, Bill has made time to see Mikki to check in with her before her appointment with Dr. Wright.

MIKKI: Hi. Kate said you wanted to see me.

COUNSELOR: Hi, Mikki. It's good to see you again. Things were pretty tough for you the last time we were together. Kate has been keeping me updated; it seems things are going a lot better.

MIKKI: Yes, they are. I need to get a job and a better place to live, but the girls are doing better.

COUNSELOR: And you? How are you doing?

Transitional and Permanent Supportive Housing

Two primary approaches to housing services include transitional supportive housing and permanent supportive housing. Transitional services are designed for people needing more than emergency housing assistance, but with an expectation that within a period of approximately 2 years, they will be able to move away from supported housing using their own resources. Many people are able to move from transitional housing sooner. Some examples of clients who often need transitional housing are families whose major breadwinner has lost a job and been unable to find other employment, people who are homeless when leaving substance abuse treatment, and families affected by domestic violence. Typically, transitional housing is accompanied by social, health, behavioral health, and other services to support the individual or family in rehabilitation from homelessness.

Permanent supportive housing is more likely to be an appropriate choice for individuals who face long-term rehabilitation from homelessness and have co-occurring behavioral health or physical disabilities. Permanent supportive housing needs to be accompanied by a variety of social, health, behavioral health, financial, occupational, and interpersonal services to enable the individual to function optimally in the face of difficulties.

In both transitional and permanent supportive housing, the type of appropriate housing depends on a variety of contexts, including housing availability in the community, the specific needs of the individual or family, cost, and the availability of adjunct services. The housing may range from SRO units to conventional apartments in the community.

Source: HUD, 2008.

MIKKI: Well, better. I'm sleeping at night, even though the Family Living Center is loud and our room faces the street with traffic all night. I've got to find a better place to live, but that takes money. I'm also just sitting around all day. There isn't much to do. They don't like you downstairs watching TV all day.

COUNSELOR: What about drinking?

MIKKI: No drinking. When I saw the doctor, he told me I should quit, and the support group has helped a lot, too. I really couldn't afford it anyway. Mostly, I drank at night to sleep better, but I think I'm sleeping better now without drinking. My boyfriend drank every day, and I got to drinking with him. Now I'm through with him and the drinking.

Master Clinician Note: The counselor decides to monitor Mikki's progress with not drinking as he continues to maintain contact with her; he also wants her to have options for help if she does begin drinking again.

COUNSELOR: What do you think would be helpful for you if you did find yourself drinking again?

MIKKI: Well, I don't think that is going to happen, but I guess I would just stop.

COUNSELOR: And if you find that despite your intentions, you can't stop?

MIKKI: Well, could I give you a call?

COUNSELOR: Sure, I plan to be around a while. But also, if you aren't able to reach me, for instance, maybe you've moved away, would you be willing to contact some resource in the community that could help you—for instance, a local alcoholism clinic or AA?

MIKKI: Well, I really don't intend to start, but sure—if I see that I'm drinking again, I can do that.

Master Clinician Note: The counselor knows that Mikki would benefit from discussing how she would know when to seek help. He can also provide additional contact information that might come in handy in the future. He also wants to encourage Mikki to attend some AA meetings but decides to wait on that suggestion because of the multiple issues she still needs to address.

COUNSELOR: Have you heard from your boyfriend?

MIKKI: No, not a word. I don't know if he would even be able to find me now. I'm not wanting to find him right now, either. Maybe he was more of a problem than a solution.

COUNSELOR: Well, Mikki, I'm really happy to see you doing so much better. We have a few minutes before your appointment with Dr. Wright, so I'd like to talk with you about the girls. I know you've seen Annette, Madeline's school counselor, at least once since we last met. I talked with her last week. She would like to see Madeline get into some support programs if that's okay.

MIKKI: What kind of programs are you talking about?

COUNSELOR: Well, one is an after-school program that runs until 6 each school day. It would help Madeline have a place where she could be with other kids after school. She would get a snack, have a chance to rest, and get her homework done. Annette says she also thinks she can get Emily into an afternoon preschool program that goes from 1 to 6 in the same building where Madeline would be. That would give you some time to yourself to begin getting things together in your life.

MIKKI: I could use some time to look for a job. What do I need to do about seeing this lady to get help for Madeline and Emily?

COUNSELOR: While you're seeing Dr. Wright, I'll see if I can reach Annette. Maybe we can arrange a time for you to go by her office at the school. Why don't you check with the receptionist's desk after seeing Dr. Wright? If I'm with someone else, I'll leave you a note there. If not, the receptionist will let me know you are available.

[Mikki proceeds to Dr. Wright's waiting room. Bill calls Annette's office, and they arrange an appointment time for Mikki to visit with Annette tomorrow.]

The next day

Mikki arrives at Madeline's school about an hour before school is let out, and she meets with Annette. Annette does arrange after-school services for Madeline and also enrolls Emily in afternoon preschool services. Annette also arranges for two other important services for Madeline: a support group similar to the Curriculum-Based Support Group Program she has read about and a summer program based on Coping Cat, which she saw on the Internet.

Five months later

Mikki drops by Bill's office while she is at the health center with Emily, who is getting immunizations. Mikki started out seeing Bill once a week for a couple of months, and then they decreased their visits to every other week. When she got a job, it became difficult to schedule appointments with Bill, so she began checking in via telephone. She is now working 6 hours a day as a housekeeper in a local upscale hotel. Emily is in child care while she works. The family

Evidence-Based Prevention Practices for Children

SAMHSA's NREPP is an annotated list of programs for which there is empirical evidence of effectiveness (see http://nrepp.samhsa.gov/). Among those are the two to which Madeline has been referred.

The **Curriculum-Based Support Group Program** is based on cognitive–behavioral and competence-enhancement models. It is designed to teach life skills and offer emotional support to help children like Madeline cope with difficult family situations; resist peer pressure; set and achieve goals; refuse alcohol, tobacco, and drugs; and reduce antisocial attitudes and rebellious behavior. The school has prepared a workbook for parents of children in the group and will host a late afternoon parents' session with supervised games and activities for the children.

The school's **Coping Cat** program combines summer camp activities with cognitive–behavioral treatment that assists school-age children in (1) recognizing anxious feelings and physical reactions to anxiety; (2) clarifying cognition in anxiety-provoking situations (e.g., unrealistic expectations); (3) developing a plan to help cope with the situation (i.e., determining what coping actions might be effective); and (4) evaluating performance and administering self-reinforcement as appropriate.

Coping With Work and Family Stress

This workplace preventive intervention is designed to teach employees 18 years and older how to deal with stressors at work and at home. The sixteen 90-minute sessions, typically provided weekly to groups of 15–20 employees, teach effective methods for reducing risk factors (stressors and avoidance coping) and enhancing protective factors (active coping and social support) through behavior modification (e.g., methods to modify or eliminate sources of stress), information sharing (e.g., didactic presentations, group discussions), and skill development (e.g., learning effective communication and problem-solving skills, expanding the use of social networks). The curriculum emphasizes the role of stress, coping, and social support in relation to substance use and psychological symptoms. Usually, a facilitator with a master's degree who is experienced in group dynamics, systems theory, and cognitive and behavior interventions leads the sessions. For more information, visit the NREPP Web site (http://nrepp.samhsa.gov).

last week moved into supported housing, a program for formerly homeless families. Mikki has continued to see the psychiatrist and a social worker at the health center regularly and is much improved. She continues to maintain abstinence and is able to help Madeline with her homework; last weekend, the three of them went to a local community fair and had a great time. This weekend, they are shopping at local used furniture outlets for furniture for their new apartment. Mikki is taking advantage of a program offered by her employer (see text box above) to help prevent her stress from becoming a barrier to her keeping her housing and maintaining abstinence.

Long-range plans for Mikki and her children are:

- For Mikki to continue receiving treatment and support services at the local health center:
  - To stabilize in remission from her depressive episode.
  - To learn more about how to manage her recovery from her depression and alcohol use and to act early if she perceives a relapse coming.
  - To continue to develop better coping and parenting skills.
- To stay on the list for Section 8 housing and to move when this becomes available.
- For Mikki to continue to make plans with her parents to possibly return to her hometown (in the same county) to live with her daughters. These plans would include contingencies for:
  - Local supported housing.
  - Continuing mental health services.
  - Signs of trauma reactions in the children related to what they have experienced in the past year.
  - Making plans to obtain long-term employment.
  - Maintaining abstinence from alcohol.

Vignette 7—Sammy

Overview

Sammy is in the permanent supportive stage of homelessness rehabilitation. The vignette shows approaches and techniques for arranging PATH-supported services and housing for a client who has SMI.

Sammy, a 34-year-old man, was discharged from the State hospital last week and referred to a community mental health center (CMHC) for continuing care; he has yet to contact them. He

spent his first night after discharge with his parents but argued with them the next morning and left. He then spent several nights with a friend with whom he stayed occasionally before his hospital admission. Last night, he had a few beers and was arrested for public intoxication, creating a disturbance, and panhandling. He spent the night in jail and this morning, as an alternative to incarceration, agreed to meet with the street outreach program staff. Street outreach in this community is a joint venture of a coalition of homelessness programs and the local CMHC. After the initial interview in jail with a mental health PATH caseworker, it was decided that Sammy would go with the caseworker to Welcome Home, a transitional housing program, and apply for long-term supported housing. The PATH caseworker will follow Sammy's progress and help him transition to the community while maintaining housing at Welcome Home.

Learning Objectives

- Use community housing and behavioral health resources to help an individual live in the community and avoid rehospitalization.
- Help clients learn about and access permanent supportive housing with support from the PATH staff.
- Provide client-directed, recovery-oriented services for housing.
- Integrate community mental health services (e.g., ACT) into a client's recovery program.

Strategies and Techniques

- Engage the client in community services to support recovery and get permanent supportive housing.
- Support the client in making housing decisions.
- Use community recovery resources (e.g., National Alliance on Mental Illness [NAMI]) to create ongoing recovery support.

Counselor Skills and Attitudes

- Develop rapport with a client who does not easily engage with others.
- Manage client resistance to accepting permanent supportive housing.
- Assess client strengths and limitations in developing a housing plan.
- Understand community resources for housing for clients with SMI.

Vignette

Visit 1 (Welcome Home offices)

Mike, a mental health caseworker, spent a few minutes developing rapport with Sammy, gathering some history and assessing his current life situation. This information revealed that Sammy has not had a permanent residence for nearly 4 years. He has lived primarily at a deer hunting camp in the forest about 20 miles from his hometown. He maintains the camp for the hunters who own it in return for a room of his own there. When he comes to town by bus or hitchhiking, he may spend a night or two with his friend. He has had three admissions in the past 8 years to the State psychiatric hospital, all related to going off antipsychotic medications and using alcohol. Between hospitalizations, he has intermittently received care at the local CMHC. He doesn't like taking medication due to side effects but recognizes that he needs to take it to stay out of the hospital.

What Is PATH?

Projects for Assistance in Transition from Homelessness is a SAMHSA-administered formula grant program that funds community-based outreach, mental health, substance abuse, case management, and other support services for individuals who are homeless or at risk of becoming homeless and have a serious mental illness or co-occurring disorders. The program was authorized by the Stewart B. McKinney Homeless Assistance Amendments Act of 1990. Monies are distributed by SAMHSA's Center for Mental Health Services to States, the District of Columbia, Puerto Rico, and the U.S. Territories. States then distribute the monies to local programs to meet defined local needs. In this sense, each local PATH-funded program is different, reflecting the unique needs of the community it serves. For more information, visit the PATH Web site (http://pathprogram.samhsa.gov/).

PATH providers work with service delivery systems and embrace practices that work by:

- Partnering with Housing First and permanent supportive housing programs.
- Providing flexible, consumer-directed, recovery-oriented services to meet consumers where they are in their recovery.
- Improving access to benefits, especially through Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI), Outreach, Advocacy, and Recovery (SOAR).
- Employing consumers or supporting consumer-run programs.
- Partnering with medical providers, including Health Care for the Homeless and community health centers, to integrate mental health and medical services.
- Improving access to employment.
- Using technology, such as hand-held devices, electronic records, and Homeless Management Information Systems.
- Training local provider staff on strategies to help people with serious mental illness who are homeless.

Local PATH-supported organizations provide homelessness support services, including:

- Outreach.
- Screening and diagnosis.
- Habilitation and rehabilitation.
- Comprehensive community-based mental health treatment.
- Alcohol and drug treatment.
- Case management.
- Supervision in residential settings.
- Services to help clients access appropriate housing.

About 6 years ago, Sammy lived briefly in a group home, was involved in a local drop-in day program supported by NAMI, and was able to work part time at a local carwash. Sammy says he prefers to live alone; living in the group home was "too close" for him. He felt too many pressures, and the staff's expectations were too high.

The vignette starts with Sammy and Mike (the counselor) as they consider alternatives for housing.

COUNSELOR: Sammy, let me see if I'm understanding you correctly. First, you need a place to live, at least for a while, because the guys at the deer camp say you need to prove you can do okay and stay out of trouble before you go back out there to live. Second, going home to your parents doesn't seem like a very good idea. Third, you need a place that you can call your own, without sharing a room, and lastly, you need a place you can afford. Am I correct about all of this?

SAMMY: Pretty much. I don't want to go back to my parents' house or a group home. Been there.

COUNSELOR: Okay. Here's the way I see things. Let me know what you think. Number one is that we need a place for you to just hang your hat for a while until we can find a longer-term solution.

SAMMY: [*interrupting*] What do you mean, "hang my hat for a while"?

COUNSELOR: Just a place for you to stay, maybe a week, maybe longer, until we can help you find a place, arrange for financial support, get you hooked up with the ACT team at the mental health center. That sort of thing.

SAMMY: I could just live with my friend until you find me a place.

COUNSELOR: Remember that the judge this morning made finding adequate housing, getting involved with the mental health center, and getting settled in conditions for staying out of jail.

SAMMY: I don't want to go back to that jail. Place smells. And it's noisy.

COUNSELOR: Okay, Sammy, here's what I'm thinking. I know I can get you a room, at least for a week, at the local shelter. I was over there yesterday, and they have some room. Would you be willing to go over with me and take a look?

SAMMY: Uh-huh. I guess so.

COUNSELOR: Okay, just in summing up, let's see what we need to do from here. We're going to take care of your housing for the next few days by going over to the shelter office. But also, if it is okay with you, I want to call Jeanette, who is on the ACT team at the community mental health center; let's get your appointment arranged. You've been through a tough 24 hours, and I want to be sure you have some support so you can minimize things turning tough again. And then we have to get you some money so you can buy a few things like a razor, and maybe a duffle to keep your meds and stuff.

SAMMY: I've got some money; my parents gave me $100, and I still had about $35 when I left the jail this morning.

COUNSELOR: Great! Maybe that'll last you for 2 or 3 days. The shelter will take care of your food. Now, I need your permission on a release of information form to call Jeanette. Is that okay?

SAMMY: Uh-huh.

[Mike proceeds to complete the release of information form and explains it to Sammy, who then signs in the presence of the housing office secretary and Mike. Mike then calls the shelter office to be sure someone will be available to meet with Sammy and him in about an hour. He then calls Jeanette at CMHC in Sammy's presence, but she is unavailable and will return the call that afternoon.

Mike and Sammy then proceed to the shelter office, where they arrange housing in an SRO setting for the next week. Back at the office, Mike gets the call from Jeanette and makes an appointment with Sammy for the ACT team tomorrow morning. He calls the shelter office, which passes the information about the appointment on to Sammy. Mike will accompany Sammy to his first visit at CMHC.]

Visit 2 (meeting with the ACT team)

Before meeting with the ACT team, Sammy and Mike spend a few minutes in the park across from CMHC. Sammy says that his room at the shelter is "better than the jail, but not much." He is very interested in getting his own apartment as soon as possible. Mike agrees that they will meet tomorrow and begin working on finding an apartment through the PATH-supported services program. Mike is also concerned that Sammy needs a range of services to meet a variety of needs: housing, mental health treatment, something to do during the day, developing interpersonal supports in the community, gaining income, achieving family reconciliation, ensuring proper nutrition, obtaining transportation, and so on.

No one program in the community can address all of these needs, and Mike will be the initial linchpin in coordinating these services. Mike begins to prioritize mentally how he will approach this task of coordination. As the ACT team engages Sammy, most responsibility for his care will be handed off to the ACT team; Mike will begin to withdraw from active participation in Sammy's treatment.

When it is time for Sammy's visit with the ACT team, Mike accompanies him across the street. Sammy first meets with Jeanette, an ACT team social worker, who completes the intake interview. Sammy and Mike then meet with the entire ACT team, and they jointly come up with a short-term treatment plan that includes:

- Regular prescription medication and compliance monitoring by the ACT team with Mike's support.
- Daily contact with the ACT team Monday through Friday for the first month, with a plan to

What Is an ACT Team?

ACT is an evidence-based practice (see http://nrepp.samhsa.gov/) developed in the late 1960s. ACT (sometimes known as PACT) teams provide intensive, individualized care, including direct treatment, rehabilitation services, and support services to persons with chronic and persistent mental illness 7 days per week (sometimes 24 hours a day). ACT care is distinguished from traditional community mental health services in that ACT team members work collaboratively to provide most services. The client is a client of the team, not of an individual service provider. In traditional mental health treatment, services are provided by a variety of different practitioners in a variety of settings, leading to fragmented and sometimes contradictory care. Team members in ACT include psychiatrists, psychologists, social workers, licensed mental health counselors, nurses, rehabilitation counselors, and recently, peer counselors.

Some principles of ACT, as identified by the Assertive Community Treatment Association, include:

- The ACT team is the primary provider of services.
- Services are provided in the client's environment, as well as in the ACT office.
- Services are highly individualized.
- ACT teams act assertively to encourage clients to participate in recovery.
- Services are provided over a long term.
- There is an emphasis on vocational services.
- The team provides substance abuse services and psychoeducation.
- Family support services are provided.
- Clients are supported in engaging and integrating into the community.
- Healthcare needs are addressed through education, evaluation, referral, and follow-up.

What Is NAMI?

NAMI is a nationwide voluntary organization with 1,200 affiliates throughout the United States that advocates for better understanding and resources for people with mental illnesses. It provides a variety of services and resources, including the NAMI Center for Excellence. Some basic services that might be provided in a community program supported by NAMI or another organization could include psychosocial skill training, mental health rehabilitation, case management, designated payee services, and drop-in services for clients and, possibly, their families.

taper contact to three times weekly in the second month, then once weekly after 3 months.
- Daily attendance at a local NAMI-supported recovery group at CMHC for 3 months.
- Weekly attendance at a contemplation/preparation/action co-occurring disorders group at CMHC.
- Collaboration between Mike and Sammy in a transitional manner until Sammy is in permanent housing, then transfer of all services to the ACT team.
- Contact information for 24/7 access to the ACT team in case of any psychiatric emergencies.

[Sammy, Mike, and the ACT team agree to the terms of the treatment plan, and all participants sign it. Sammy will begin the NAMI support group tomorrow morning and will check in with the ACT team during his morning NAMI meeting. Mike makes an appointment with Sammy to meet the following afternoon to begin the application for a supported housing apartment.]

Visit 3 (counselor's office)

Mike and Sammy meet to begin the application process for Sammy to obtain an apartment through the supported housing program.

SAMMY: I don't like this shelter thing. People are everywhere, and they all talk too much. It's just like the group housing thing I was in back a few years ago!

COUNSELOR: You seem to be getting uncomfortable with all the people. How are you handling that?

SAMMY: Well, they make you leave the place by 9 in the morning, so I go over to the NAMI program. And then they won't let you back in until 4:30, so after NAMI is over, I just hang in the park. Don't know what I'll do if the weather gets bad. Then once I get back in the shelter, I just go to my room. But I can still hear them through the walls. My room is right over the community room. They've got that TV blaring, and then the people have to talk even louder. I don't like it. It's too loud. At the deer camp, I could go 3 days without hearing anything but the crickets.

COUNSELOR: Sammy, I really understand that, and I know that it's making you uncomfortable. But I'm wondering if you can just hang in there until we can work out something better. Maybe have your own place in a week or 10 days. Could you do it?

SAMMY: Well, do I have a choice?

COUNSELOR: I don't know. What do you think? I hear that this makes you uncomfortable; remember that you and I, working together, are going to try to get you a better place as soon as we can. You're going to have lots of say in the place you get, where it is, how it looks. You'll even meet with the landlord before we close the deal. Meanwhile, you need to decide if you can hold

out until this lands, which it will. Let me ask you: In the past, when things have been noisy, what's worked best for you to deal with it?

SAMMY: Well, I've had some beer. But I know I can't do that right now. Sometimes I put on headphones and listen to music. That helps sometimes.

COUNSELOR: That sounds like a great idea to experiment with again.

SAMMY: Okay.

COUNSELOR: Let's get some details about your housing needs, how you'll pay, and your preferences.

[Mike and Sammy continue to discuss the details of Sammy's housing needs. Sammy has concerns about the neighbors, his privacy, rules that might be imposed on him, and who can access his apartment. Mike is concerned about public transportation availability, a cooperative landlord, finding an apartment in the rental range Sammy can afford, and the quality of the apartment. Mike encourages Sammy to apply for SSDI support, and his lead clinician on the ACT team will participate in arranging for him to have an appointment to begin the process at the local Social Security office. A local NAMI recovery coach will also assist him in the process. This process can take 6 months to a year, and, in the interim, the local homelessness coalition will pick up the costs of Sammy's rent. After (if) he is approved for SSDI, then 30 percent of his check will be applied toward the cost of the apartment. Likewise, if he doesn't receive SSDI, but finds another source of income, a portion of that income will go toward his rent.]

Master Clinician Note: The kinds of information Mike might want to collect to help Sammy find a suitable apartment could include the following:

1. What area of town does Sammy want (or not want) to live in?
2. Is Sammy aware of any apartments that he thinks would be suitable?
3. What about bus routes or other available transportation in the area?
4. Are there grocery and other stores in the area that Sammy can use?
5. Are there laundry facilities in the apartment itself, in the apartment building, or nearby?
6. Can Sammy easily access his mental health service provider for appointments?
7. Are utilities included in the rent? If not, are there utility deposits, and who will pay the deposits?

Visit 4 (in the community)

The next day, Sammy and Mike go apartment hunting among the apartments approved by the local affordable housing program. They look at several furnished units, each having some disadvantages for Sammy's particular situation. The fifth apartment visited seems to meet Sammy's needs and seems to Mike like a good match. It is an upstairs one-bedroom unit in a building with seven other apartments, about six blocks from CMHC, and it's near a grocery store. The unit has a small, parklike lawn in front, is on a bus route, and seems secure. The basement includes a washing machine and a clothes dryer. It has minimal but acceptable furnishings. Sammy was initially concerned that there was no TV but then said he thought his parents would let him have the old TV from his room at their home. The rent is $400 a month, which is within the

range of affordability for the housing program. There are two other units rented to participants in the PATH housing supports program.

> **Master Clinician Note:** The counselor needs to know how housing is approved or preapproved for supportive housing programs. All supportive housing programs investigate potential housing units prior to their eligibility in the program. Most programs have Housing Quality Standards criteria that must be met. The program is also likely to want statements from the owners of the available units that they are willing to work with the housing program. Before signing a lease, renters need to have a clear understanding of a variety of issues: for instance, whether the lease will be in the name of the program or the client, whether there is a deposit and how much it is, whether utilities are included in the rent, whether smoking is allowed in the apartment, arrangements for pest control, and whether there are rules about visitors. Many programs must complete a HUD-required Rent Reasonableness Survey to ensure that the rent is in line with community standards.

Sammy and Mike meet with the apartment manager, who lives in an apartment on the second floor adjacent to the unit Sammy will rent. He mentions that he would like to help Sammy and that he himself was a patient at the State psychiatric hospital several years ago and, after obtaining housing in the building, had become the manager about 3 years ago. Sammy, although a bit distant, seems to like him. The manager is interested in how Sammy will spend his day, goes over the basic rules of the apartment building, and offers to help Sammy get settled in.

After the meeting with the apartment manager, Sammy and Mike sit for a few minutes on a bench in front of the apartment unit.

SAMMY: So, when can I move in?

COUNSELOR: Well, here are some things we need to do first: [*Sammy sits quietly.*] First, do you think it would be a good idea to let your parents know what's up?

SAMMY: Yeah, I can give them a call. They were paying my cell phone bill while I was in the hospital, and I have it back, so I can call them.

COUNSELOR: Maybe they would like to see the place.

SAMMY: Nah. They don't need to see it.

COUNSELOR: Okay, well, what else do you need to do to get moved in once we have everything arranged on our end?

SAMMY: I don't know. Move the little stuff I have, I guess. I'll get Mom to give me some dishes and kitchen stuff. I can cook and they'll give me a little money to buy some food—pasta and that kind of thing. I don't eat much. This medicine makes me fat if I eat too much.

COUNSELOR: What about sheets, toilet paper, that sort of thing?

SAMMY: Well, I know I can't keep my mom from coming over here, once she knows where I'm living, and she'll bring that stuff.

COUNSELOR: Okay, now, you'll be going to the NAMI Recovery Program every day, and, for now at least, you'll be checking in with the ACT team. Every week, you get your meds from them. I think you are all set, Sammy.

Visit 5 (NAMI Recovery Program facility)

Ten days later, Mike checks in with Sammy while he is attending the NAMI Recovery Program. Sammy has moved into his new apartment and watched a football game with Frank, his apartment manager, last evening. He has made some acquaintances with other participants in the NAMI Recovery Program. Sammy and Mike find a quiet corner to visit for a few minutes.

SAMMY: I'm going to go out to the deer camp for a few days next week.

COUNSELOR: What about your participation in this recovery program and your ACT team visits?

SAMMY: What about 'em?

COUNSELOR: Well, my understanding of our agreement is that you are supposed to participate in these programs every day.

[Sammy doesn't answer, and there is a long pause.]

COUNSELOR: So, Sammy, let's see. If I understand you correctly, you want to go visit the deer camp, and we need to find a way for that to happen that doesn't interfere with your ACT team involvement and your participation in the NAMI Recovery Program. How do you envision doing that?

SAMMY: I'm just going for a few days—to check on things.

COUNSELOR: And you would be going by yourself?

SAMMY: Yeah, I'll take a bus out. They let me out at the old road to the camp and then I walk the last mile or two.

COUNSELOR: And Mr. Devereaux, the head of the deer camp group, knows you're coming?

SAMMY: Nah, but he doesn't mind. We're friends.

COUNSELOR: Well, Sammy, I see a couple of problems. First, our agreement calls for you to not miss daily contact with the ACT team for your first 30 days and for you to not miss NAMI meetings. Second, I think we at least need to talk to Mr. Devereaux and let him know you're planning to go out to the camp, how long you'll be there, how you would get into the building, that sort of thing.

[Sammy agrees to give Mr. Devereaux a call in Mike's presence. Mr. Devereaux greets Sammy warmly, but reminds him that he left the deer camp "in a mess" and that he can only return when others are there and the mental health center has given its approval. Following the call, Mike and Sammy agree that Sammy will defer the visit to the camp for a few months. Sammy is disappointed but accepts the decision. Mike acknowledges Sammy's disappointment and supports his

trying to make it work by clearing it carefully with Mr. Devereaux as well as his continuing participation in his recovery efforts.]

Three months later (follow-up)

Sammy has been active in NAMI now for 3 months. Working with the ACT team, he has managed to balance the amount of medicine he takes so that it can control his symptoms while not making him feel "dopey." Mike is tapering off his involvement with Sammy, transitioning responsibilities to the ACT team. Sammy has made a couple of friends through the NAMI Recovery Program and, with the help of the ACT team, has found part-time employment with a local moving company. He is also planning to enroll in a course on electronics repair at the community college next month. A core element of his recovery has been his ability to maintain supported housing, which gives him an element of independence yet continues his access to treatment. The combination of PATH support, supportive housing, mental health services at CMHC, NAMI rehabilitation services, and interim financial support has given Sammy a strong foundation for recovery.

Summary

Sammy has a history of SMI and was at significant risk of relapse before adequate supportive housing was made a part of his recovery plan. It is also essential that he continue to be engaged with local community behavioral health resources, such as the local ACT team and NAMI. He was able to accept temporary housing in a shelter until permanent supportive housing was arranged and, with a supportive landlord and community resources, has made a good transition to the community.